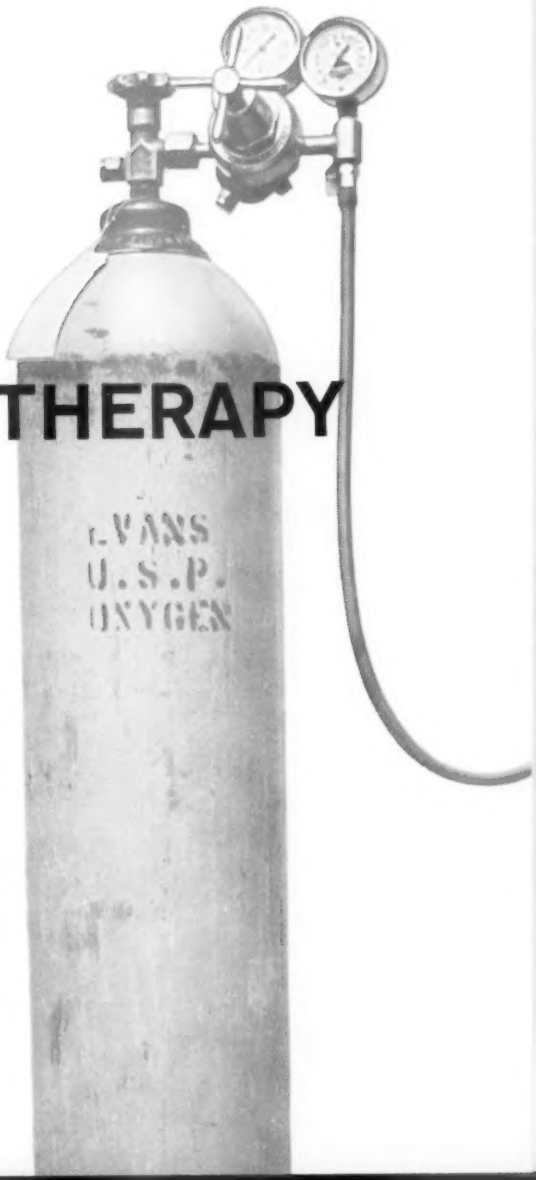
RN

OCTOBER 1959



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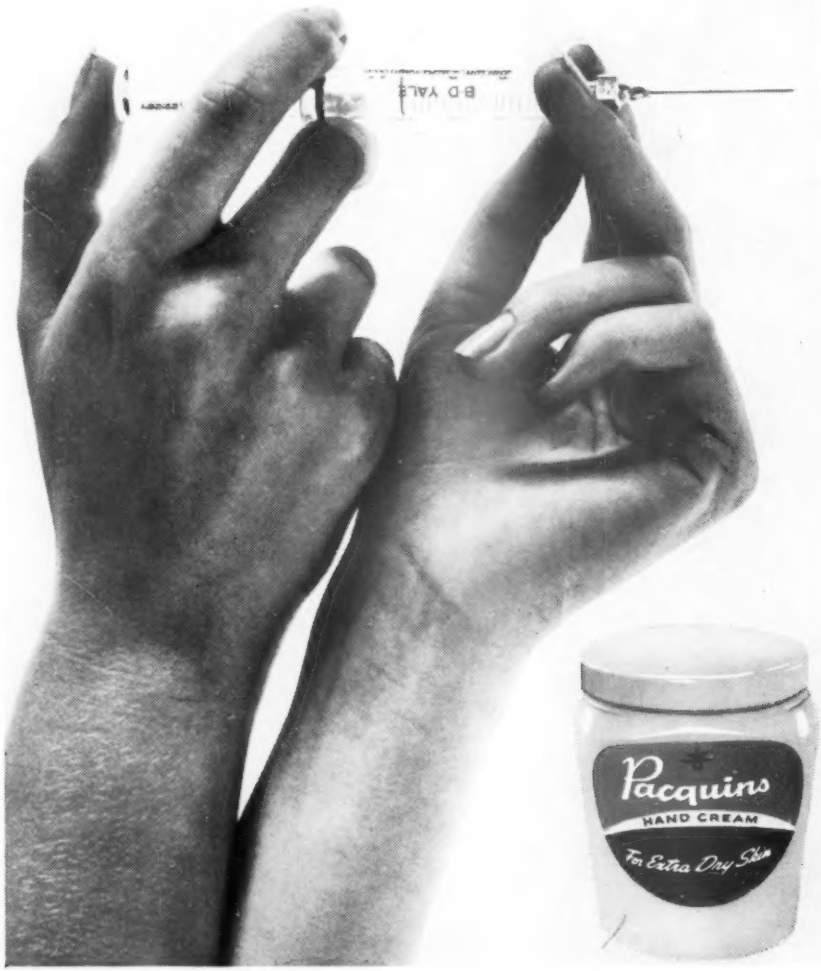

RN contents

VOLUME 22 • NO. 10 • OCTOBER 1959

MORE ▶

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"What a day!"

"When you're assisting a doctor in private practice, there's no telling what the day will bring. Today it seemed as though the whole neighborhood had to have one injection or another. It took me hours just to clean up."

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*Weinstein, J. J.: Bowel Preparation for Anosigmoidoscopy with a Hydragogue Enema. To be published.

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- Valuable adjunct in management of monilia, trichomonas, staphylococcus and streptococcus vaginal infections.

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In contrast, the *buffered* acid douche solution of Massengill Powder (pH 3.5-4.5) resists neutralizing. The normal, low pH is maintained for 4 to 6 hours and as long as 24 hours in recumbent patients. This low pH inhibits the propagation of monilia, trichomonas vaginalis and pathogenic bacteria. However, the beneficial Döderlein bacillus thrives in this pH range.

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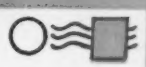

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Folic acid	3 mg.
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*Seriously ill patients, particularly those with neurologic symptoms, also need parenteral therapy

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Reference: 1. Goodman, Louis S. and Gilman, Alfred: *The Pharmacological Basis of T peutics*, Sec. Ed., 1955. 2. Brownlee, George: *A Comparison of the Antipyretic Activi Toxicity of Phenacetin and Aspirin*, Quarterly J. of Pharmacy and Pharmacology, 10:60

RN letters

'. . . GREATEST WEAKNESS'

DEAR EDITOR: " 'Hospital Nursing's Greatest Weakness' " (*RN*, July) presents a valid point [the need for better intrastaff communication]. But, as the old saying goes, you've got to catch your rabbit before you can cook it.

In this case, before you can hope to "pass the word" successfully from shift to shift, you first must "catch" an adequate staff.

Also, you must find a way to insure *uninterrupted* reporting. *That* could be quite a trick!

Edna Davis, R.N.
El Paso, Tex.

DEAR EDITOR: I agree with the author that communications could be improved. Yet her message sounds hollow to me.

First, there's her incredible suggestion that it's a waste of time to pass wash water to patients in the morning. The damp washcloth she would substitute could hinder, rather than improve, communication with the patient.

Another point: Is it enough for the nurse to know only that a patient refuses a tray, or is frightened or depressed?

Shouldn't she also know *why?* Patients need to be communicated *with* as well as *about*!

When a nurse starts out to champion an ideal, there's always the danger that the patient may be neglected.

At any rate, let's not dispense with the soap and water— and let's not succumb to Organization Thinking.

Shirley M. Payne, R.N.
Boston, Mass.

DEAR EDITOR: . . . a most interesting and enlightening article!

Few nurses take notes during report. As a result, many fail to pass important information along to the next shift. Since student days I've found note-taking invaluable in helping me carry out my duties.

William H. Nace, R.N.
Philadelphia, Pa.

UNLIMITED VISITING

DEAR EDITOR: Your article " '. . . as Well as Can Be Expected' " brings to mind an experience I had as head nurse in a busy premature nursery.

I was a "chief" who seldom had

letters

the help of any "Indians." When visiting hours arrived, my moments were usually so full of babies that I rarely had time to pay attention to parents.

I knew the parents of a preemie needed a lot of briefing before they took charge of their baby. So, contrary to front-office policy, I told parents to come whenever they could. Result: The parents were pleased and I was able to teach them what they needed to know.

Gladys M. Temple, R.N.
Balboa, Canal Zone

OSTEOPATHY CLARIFIED

DEAR EDITOR: Your July article on osteopathy is very informative. It cleared up a lot of misconceptions for me.

Bessie L. Dudding, R.N.
Huntington, W. Va.

YOUNGER vs. OLDER

DEAR EDITOR: I write in reply to the letter that says, "Older graduates resent taking orders from these young upstarts who've been graduated for only a year or so."

But what happens when a young graduate finds that an older graduate who returns to nursing has become rusty? The young graduate wants to help her co-worker, but the older graduate resents any offer of help.

In being resentful and critical of each other we lose sight of our most important responsibility: the patient.

More▶

letters

Older and younger *can* work together—and the combination can make for a well-rounded staff.

Ludwell Newcomb, R.N.
Norfolk, Va.

MASTECTOMY PATIENTS

DEAR EDITOR: Your excellent article on breast surgery (*RN*, August) prompts me to make this point. All prospective mastectomy patients should be told about suitable prostheses by their doctor or by a well-informed nurse.

I was told nothing, either before or after my double mastectomy. I had to find a satisfactory breast form by trial and error. Now I tell all my mastectomy patients about this form. You'd be amazed at their improved mental state after they find out they won't have to look disfigured.

Eileen Rocksvold, R.N.
Woodland, Calif.

PRIVATE DUTY FEES

DEAR EDITOR: I disagree with "R.N., California" who says private duty nurses are pricing themselves out of work.

Think of the expenses a private duty nurse has: dues, registration, malpractice insurance, car upkeep, health and accident insurance (to mention a few). And whenever she's ill or takes a vacation, her income stops.

Even $20 a shift wouldn't be too much to charge! I'm a head nurse and have been for years, but my

sympathy goes out to the private duty nurse.

Harrie M. Solomon, R.N.
Walnut Creek, Calif.

DEAR EDITOR: If "R.N., California" agrees with the M.D.s who consent to the use of aides for private duty, she might just as well say good-by to private duty nursing.

No doubt she herself would be the first to have a private duty *nurse*—no matter what the price—if she were critically ill.

Fern Bonamino, R.N.
Erie, Pa.

TROUBLE-SHOOTING R.N.

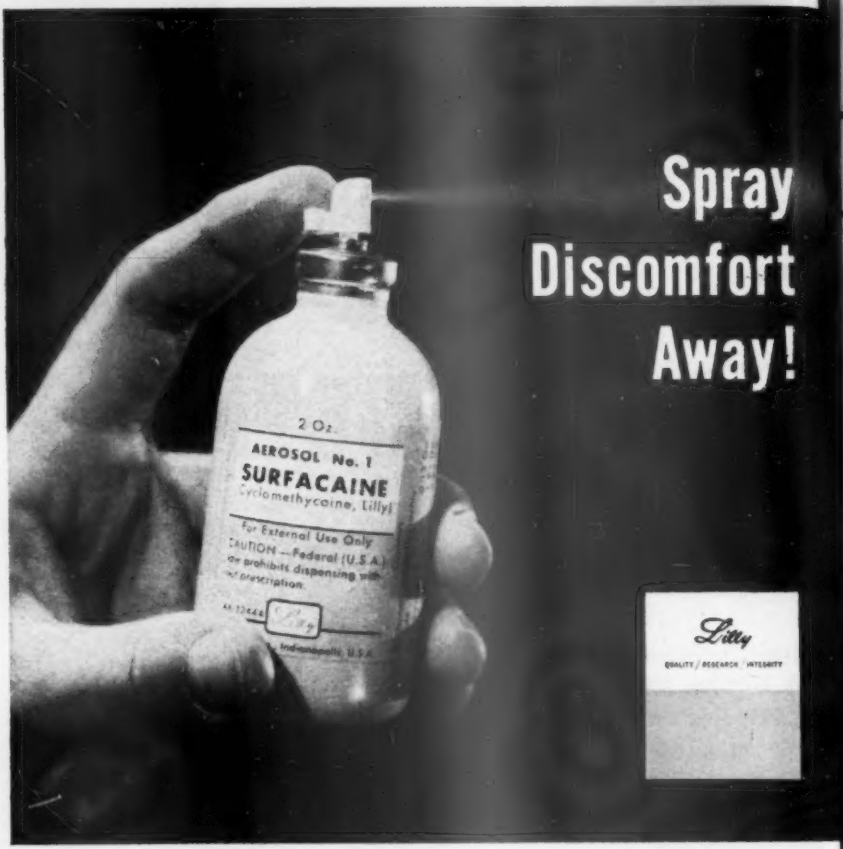
DEAR EDITOR: A recent letter refers to talk going on about "the R.N. being replaced by the degree nurse, who'll do the paper work, and by the practical nurse, who'll give the nursing care."

Before such an arrangement could become standard practice (heaven forbid!), the practical nurse would need to receive more training than she now gets. For even though some nursing duties don't require unusual skill, the nurse's bedside observations can mean the difference between life and death.

Every nursing team responsible for bedside care should include at least one well-qualified R.N. as an observer and trouble shooter . . .

Flo E. Woomer, R.N.
Gettysburg, Pa.

END



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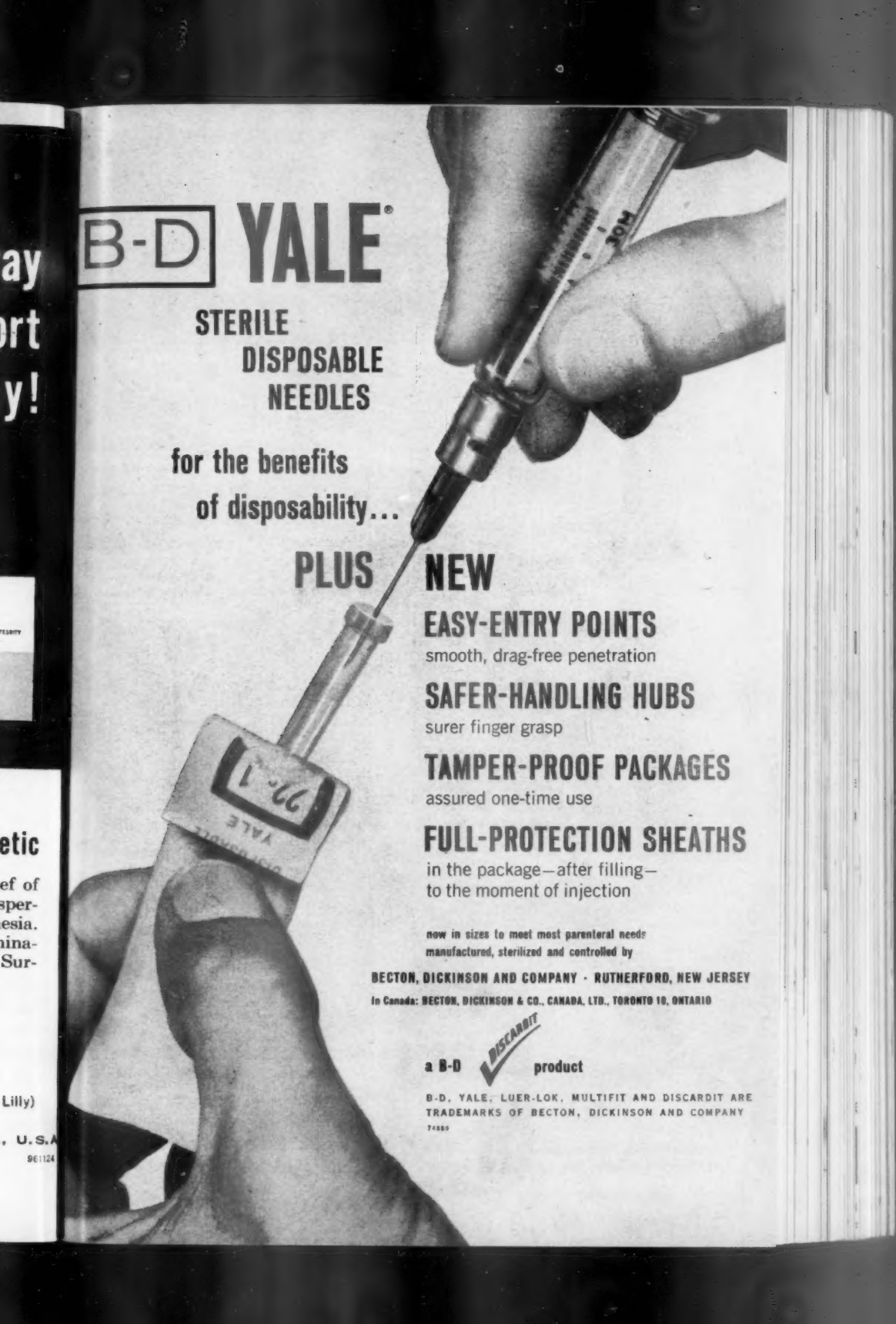
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RN news

M.D.s Report Safe Way to Simplify Baby-Feeding

With safe milk, safe water, and good refrigeration available, can today's mother safely skip the time-honored practice of sterilizing her baby's formula?

Dr. John P. Gibson of Abilene, Tex., reports in the Journal of Pediatrics that one-fourth of some 185 mothers studied in that city don't sterilize the formula; yet the incidence of diarrhea among their babies, he says, isn't any greater than among the babies of mothers who make a practice of sterilizing the formula.

In the same publication, Drs. Carl C. Fischer and Mark A. Whitman of Philadelphia report good results from the use of evaporated milk and *hot* tap water (with carbohydrates added or not, as indicated).

Their method requires these precautions:

¶ If the water comes from any but a safe city or suburban water supply, boil it for five minutes.

¶ Clean bottle, nipple, spoon, and funnel thoroughly.

¶ Clean the can of milk and open it under sterile conditions.

¶ Leave unused milk in the opened can and put it in the refrigerator at once. Use it again in less than twenty-four hours; otherwise, discard it.

¶ Discard any formula left in the bottle after the baby has been fed.

'High Fees May Doom Private Duty'

"Once there were no private duty nurses. Perhaps soon again there will be none . . . The recent [fee] increases may be the spark that will fire enthusiasm for the [progressive] care system."

So says the publication Massachusetts Physician in reference to the $17 fee that Massachusetts private duty nurses may now charge per shift.

If the increase in private duty fees *does* cause most hospitals to adopt the progressive care system, only patients who can afford "pampering" will have private duty nurses, the publication contends. The others, it predicts, will be cared for as follows:

1. Those admitted for diagnosis "or who are otherwise putting in their time" will generally "get

cough due to colds or allergy

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Dihydrocodeinone bitartrate	⅙ gr.
Ammonium chloride	8 gr.
Potassium guaiacolsulfonate	8 gr.
Menthol	q.s.
Alcohol	5%

Supplied: Bottles of 16 ounces and 1 gallon.

Dosage: Every three or four hours – adults, 1 to 2 teaspoonfuls; children, ½ to 1 teaspoonful.

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along with ward aides and some measure of self-help."

2. The average patient will get average nursing care.

3. The critically ill and the problem cases will get special care from competent staff nurses.

"There will, of course, be three appropriate price schedules," the journal adds.

O.R. Nurse Trims Linen Usage

Figuratively speaking, Dorothy Austin, R.N., has made a mountain of linen into a molehill of linen in the operating suites at Cleveland's Lakeside Hospital.

How? By designing a simplified sterile pack for minor surgery.

The standard pack, she noticed, contained many items of linen never used in minor procedures. Yet once the pack was opened, its contents had to be relaundered and resterilized.

Miss Austin's minor-surgery pack not only cuts down on this expense but also saves on linen replacement costs.

'D.N.' and 'R.D.N.' Called Illegal

If you see a woman in white in a doctor's office wearing a medical pin with the letters "D.N." or "R.D.N." superimposed on it, chances are she *isn't* an R.N.

She's a member of the American Registry of Doctor's Nurses, an organization the American

Nurses' Association says is a "commercial enterprise . . . not recognized by professional associations in the health field."

Recently the Federal Trade Commission charged that this registry misrepresents itself as a nonprofit organization when actually it's "purely and simply a money-making operation . . ."

In Florida, the attorney general has ruled that the registry, which maintained a Florida address at the time, violated the state's Nursing Practice Act.

The attorneys general of Wisconsin and California have ruled it's illegal for any non-R.N. in those states to represent herself as a "D.N." (Doctor's Nurse) or an "R.D.N." (Registered Doctor's Nurse).

Reportedly, the registry's membership has now been taken over by a new Washington, D.C., organization called the American Association of Doctor's Nurses.

Surgeon Favors Open-Air Treatment of Incision

Open-air treatment of surgical wounds has been "highly satisfactory" in more than 100 cases, says Dr. William A. Shafer, Erie (Pa.) neurosurgeon, in a report to his state medical society.

The technique keeps the wound clean, he finds, even in areas where staph infection may be present.

Here's the procedure:

¶ The O.R. dressing is removed the day after surgery, and the sutured wound is left open thereafter.

¶ A nurse washes the wound twice daily with sterile water and plain soap, observing sterile technique. (She uses either small cotton pledgets or gauze squares.)

¶ After washing away blood elements, serum, and other debris, she rinses with sterile water to remove the soap.

No antiseptic is used, adds Dr. Shafer, and no antibiotic is given at any time.

Blue Cross Tries Out Home Nursing Plan

Would an illness cost less if home nursing care were used to shorten the hospital stay? If so, how much would the savings amount to?

To find the answers to these questions, New York City's Blue Cross offered home nursing care to selected patients in a five-year experiment that ended in 1957. The final report shows that:

¶ The first 500 patients stayed in the hospital sixteen days less

per patient than they would have without home care, according to their doctors' estimates.

¶ This saved an estimated $177,000 in hospital charges. After subtracting $25,000 for home nursing care, the saving amounted to an average of $152 per patient, with a similar saving per patient to Blue Cross.

¶ By going home early, these 500 patients freed their hospital beds for an estimated 700 patients who could have used them an average of eleven days each.

As a result of the experiment, the state insurance law was recently amended to authorize Blue Cross reimbursement for specified home services.

The Social Security Administration reports that at least six Blue Cross plans are experimenting with a second method they hope will reduce hospitalization costs: using nursing homes.

capsules

A Philadelphia drug-supply firm is reportedly hiring **nurses to solicit orders** from M.D.s by phone . . .

Ten-second urinalysis: A new dip-and-read test using a paper strip

with three impregnated areas is said to give accurate results in routine screening of urinary protein, glucose, and pH factors. After the strip is dipped in the specimen, it's read at once by colorimetry . . .

A new booklet, "A Language Guide for Patient and Nurse," provides common questions and statements in 10 languages to help you communicate with **foreign-language** patients. It's available on request from Eli Lilly and Company, Indianapolis 6, Ind. . . .

Hospitals should establish isolation units for **staph-infected patients** in order to combat cross-infection, contends London's Dr. A. Melvin Ramsay . . .

Seattle neurosurgeons have reportedly developed a **rapid hypothermia** technique: They lower the patient's temperature in 20 to 50 minutes by shunting venous blood through a cooling coil immersed in ice water . . .

If a post-op patient suddenly complains that one foot is cold, he may be the victim of a **"silent" heart attack** that's pain-free but serious, says Dr. Nathan Frank of Jersey City, N.J. END

Announcing the 1960

RN AWARDS

for original articles written by registered nurses

$150 for the one article adjudged the best of those submitted

Up to $100 for all other articles found acceptable for publication

You may write on *any* subject—preferably from your *own experience*—that you feel other nurses would like to read about. Looking through past issues of *RN* will help you get ideas. Examples of such ideas:

An experience with a patient that inspired you or taught you something;

A nursing technique or method you've learned that other nurses would find helpful;

How you (or a nurse you know) have successfully coped with a personal problem related, for example, to your pay or your professional advancement or your working conditions;

Some unusual and worthwhile step your local (or other) nurses' group has taken to help the nursing profession;

What it's like to work in a particular nursing specialty or to nurse in an unusual situation.

Your article will have the best chance of winning an Award (a) if it's chock-full of *specific examples, cases, anecdotes, and experiences;* (b) if it does not preach or lecture the reader; (c) if it's written conversationally and simply yet colorfully; (d) if it does not exceed 1,500 words.

° ° °

Entries must be postmarked no later than Jan. 31, 1960, and addressed to *RN*, Oradell, N.J. Manuscripts should be typed, double-spaced, on one side of the paper, and accompanied by a self-addressed, stamped envelope.

All manuscripts will be acknowledged, but those rejected may not be returned until after the close of the contest. *RN*'s editors will be the judges; their decisions will be final.

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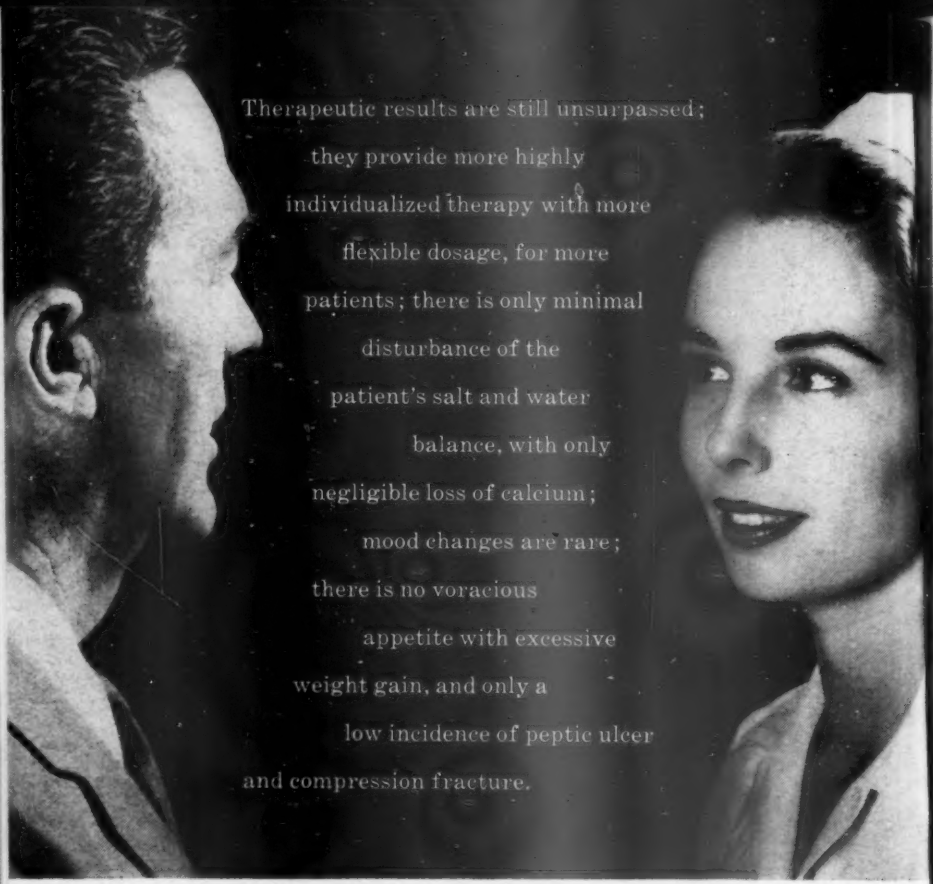

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INFANT FEEDING: A 16-page booklet is entitled "Modern Methods of Preparing Baby's Formula". It contains instructions and suggestions developed by pediatricians, nurses and hospitals for use in baby care classes throughout the country. Evenflo nursing bottles and accessories are illustrated and described. PYRAMID RUBBER CO. **K-2**

"BAREFOOT FREEDOM": This is the intriguing name of a low-heeled lace oxford, built according to exclusive principles to insure maximum comfort and support. The makers offer a booklet, "The Story of the Lace Oxford". MILLER SHOE CO., INC. **K-3**

FOOD SERVICE PRODUCTS: Every conceivable item for the preparation and handling of food within the hospital is illustrated and described in a forty-eight page color catalog, of interest to nurses who share responsibility for the selection of such equipment. BLOOMFIELD INDUSTRIES, INC. **K-4**

COTTON PRODUCTS: Various forms of absorbent cotton, pads, gauze, caps, and other related items are described in a folder, accompanied by a sample of adhesive tape. ACME COTTON PRODUCTS CO., INC. **K-5**

BANANA RECIPES: Bananas are low in calories, high in energy value, and easy to digest. How bananas fit into the various diets of illness, convalescence, over-weight and other requirements is covered in a loose-leaf folder of recipes made available by UNITED FRUIT CO. **K-6**

UNIFORM STYLES: A brochure describes garments of both general and specialized appeal to nurses. Public health nurses, particularly, can find pleasant fulfillment of their uniform needs from this source. D'ARMIGENE, INC. **K-7**

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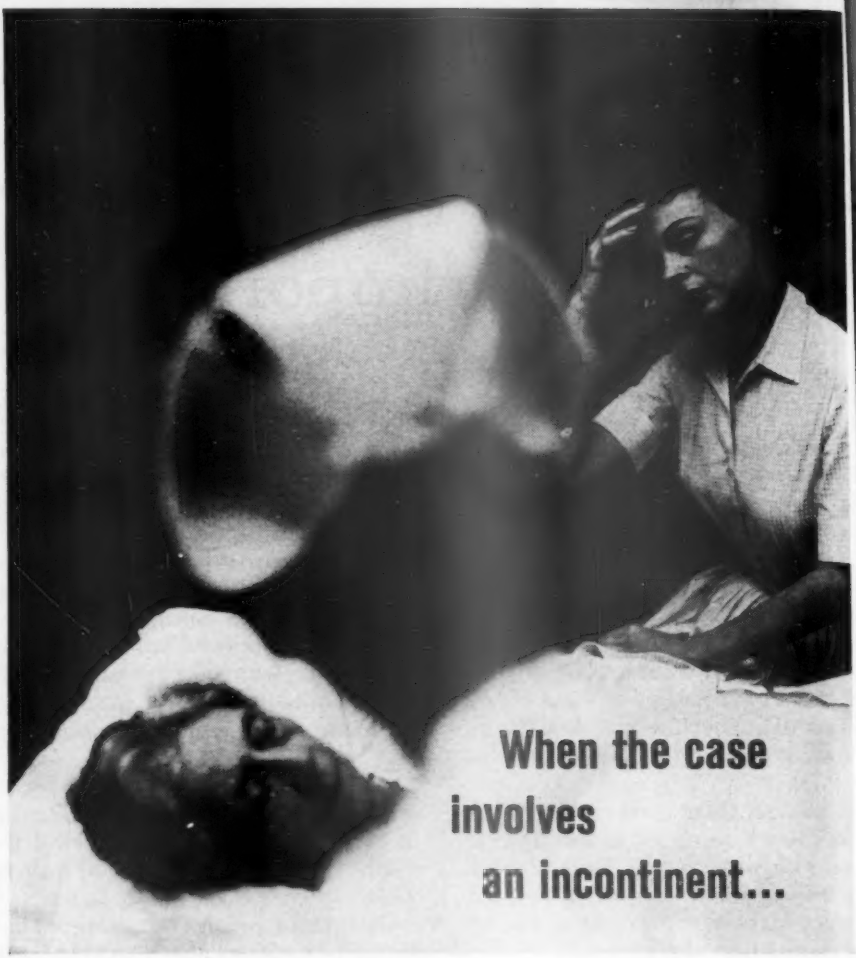

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A Patient's-Eye View of Hospital Nurses

No R.N. worthy of the title needs to be told that the aid and comfort she gives her patient are the very basis of her profession—deserving at all times of her first attention.

Yet, under the pressure of heavy schedules, some nurses, says the author, forget to put first things first.

Her prescription: See yourself as your patients see you. This article can be your mirror.

By Genevieve Burton, R.N., ED.D.

At best, a hospital is a poor substitute for the comfort and security of a home; at worst, it can be a house of horror.

We nurses realize this fact. But long familiarity sometimes makes us forget it. When we do, we fail in one of our most important duties, namely: to make the patient as comfortable as possible at all times and in all situations.

The nurse who has had the experience of being a hospital patient herself before she entered nursing has an advantage over most of us. She remembers just how scared *she* was when the hospital was still a strange place!

She also realizes that every hospital patient is fearful in some degree, depending on circumstances. And she does every-

thing she can to lessen his fear and make him feel at home.

For the rest of us, it's worth a moment to think through the experiences an incoming patient faces and think how he feels about each one.

Take the case of Mrs. J., a woman in her forties. At the time she's admitted for a series of tests, she's worrying about her yet-undiagnosed condition.

Suddenly she finds herself in a wholly unfamiliar world. She's without the security of her family. She's dependent upon strangers—people trained in their duties, it's true, but strangers none the less.

Disturbing questions flit through her mind—questions for which there may be no answers: "How long will I be here? . . . I wonder whether I have an incurable disease? . . ."

A busy admitting nurse shows Mrs. J. to a four-bed ward. The nurse doesn't bother to introduce the other three patients. (Nor do their curious stares help any.)

THE AUTHOR *is a faculty member at the University of Pennsylvania School of Nursing. This article approximates a portion of her new book, "Personal, Impersonal, and Interpersonal Relations: A Guide for Nurses" (Springer Publishing Company, Inc., New York, N.Y. $2.75.).*

Soon a young man in white appears, mumbles his name (it sounds like Dr. Mmmfff), and abruptly examines Mrs. J. He also asks numerous questions, all of which she has previously answered for her own doctor. But the interne ("Is that who he is?" she wonders) tells her nothing to relieve her anxiety.

She Gets Stabbed

Her apprehension mounts as a young woman, also in white, arrives with a basket of tubes and bottles. "I'm going to stick your finger," says the young lady —then suddenly does so with a small blade.

Mrs. J. watches, mystified, as this stranger sucks a drop of blood into a tiny tube. Then she watches the stranger ("Is she a nurse or what?") jab a needle into her arm and withdraw more blood. Meanwhile, the young lady says nothing about the whys and wherefores of these painful procedures.

Later, a woman in green appears with a supper tray. Mrs. J. nibbles at the food without relish. Later still, a nurse gives her a capsule and tells her to sleep well. (She doesn't.)

Around dawn, another nurse

comes in to give Mrs. J. an enema. This further mystifies her, since she isn't the least bit constipated. But the nurse offers no explanation.

When the breakfast trays are passed to the other patients, Mrs. J. is told she isn't to get any breakfast. But the green-clad woman does not say why.

Around midmorning, another green-clad woman takes Mrs. J. "to X-ray." The long ride in a wheel chair is followed by a long wait, much confusion, curt orders, and finally another long wait in the corridor till still another woman in [*More on 90*]

Rx for Getting Names Right

By J. Hugh Clissold

Few thing are as irritating as hearing one's name mispronounced. When the same person mispronounces it time after time, irritation becomes fury.

"Why," fumes the victim, "can't that nurse learn my name is Kowalcik?"

He pronounces it *Kowall-chick*. Perhaps the nurse has been saying *Kowull-sick*.

Anyone could make such an error. But it's no way for a nurse to win her patient's confidence. So here's what to do about it:

Ask the admitting office to write unusual names phonetically on the history sheet, after the actual spelling. For example:

GIALLOMBARDO, Rita (Mrs. Victor) (*Jee*-a-lombardo).

Then transfer the phonetic spelling to the name card on the door or at the bottom of the patient's bed. And the first time you call her by name, *ask* her if you've pronounced it right.

No need to do it for all names. Just the hard-to-say ones. Your patient will be happy that you cared enough to want to be correct. END

Risk Cases.

. . . and if she does, is she entitled to extra pay? Here's what doctors, registry directors, nursing directors, and the nurses themselves say

By Myrna Cartwright, R.N.

The private duty nurse often finds herself in a quandary when she gets a call to go on a risk case. Her moral and professional sense of duty may urge her to say "Yes" while her family obligations and other circumstances may dictate "No." Finally she may say "No"—then feel on the defensive about it.

She knows her refusal may inconvenience the registry director, the doctor, and (in some cases) the hospital. She has a haunting fear that perhaps another nurse won't be available, and thus her refusal may actually prove harmful to the patient.

HOULD THE PRIVATE DUTY NURSE ALWAYS ACCEPT THEM?

She wishes there were some clear-cut principles she could follow in each case.

By and large, just what *is* the viewpoint of the medical profession toward this problem? Do most doctors and nurses think the private duty nurse should accept risk cases? Should she accept *every* risk case she's offered, or only some of them?

And what about extra pay for such cases? It *does* exist in some cities and states. (Private duty nurses in Vermont, for example, are paid extra for nursing mental patients, those with infectious diseases, the drug-addicted, and alcoholics.) Is the profession in general for or against extra pay?

To get representative answers to these questions, *RN* queried a national cross-section of doctors, registry directors, nursing directors, and private duty nurses themselves. Here, in summary, are their opinions:

¶ With few exceptions, they agree that *every* private duty nurse should accept *some* risk cases.

¶ Two out of three believe she is *not* obligated to accept *every* risk case.

¶ Three out of five believe she is *not* entitled to receive extra pay.

One encouraging aspect of this survey: Doctors' opinions on the subject are much the same as those of nursing directors and rank-and-file nurses. They differ significantly in just one respect:

Only a *third* of the nurses queried think the private duty nurse should receive extra pay for risk cases. But *half* the doctors think she should!

Now, what are the main reasons behind the opinion that *all* private duty nurses should accept *some* risk cases?

First, it's a matter of professional and moral obligation, say

many. Dr. Homer L. Pearson Jr., chairman of the Judicial Council of the American Medical Association (which rules on ethical questions) puts it thus:

'A Moral Obligation'

"Nursing is an 'all-out' career. The nurse didn't choose it because it's easy. On the contrary, she knows it's hazardous in many instances. But as long as she's a nurse, she has a moral obligation to nurse any patient who needs her help. Naturally, she'll take advantage of available means to protect herself, such as immunization, asepsis, etc."

Second, many believe the traditional concept of risk cases is outdated and unrealistic. They point out that the risk from streptococcus- or staphylococcus-infected patients is as great today as that from the so-called risk-case patients.

Says Dr. Albert W. Snoke, director of the Grace-New Haven (Conn.) Community Hospital: "The traditional separation of one type of case from another is archaic. The problems of a complicated neurosurgical, thoracic, or cardiovascular surgical patient require just as much, if not more, nursing skill and attention as do those of mental illness or the other 'risk' cases."

Adds Dr. James L. Wilson, chairman of the Department of Pediatrics and Communicable Diseases at the University of Michigan Medical School: "There's little risk today under ordinary circumstances from patients who have, say, meningitis or tuberculosis. And in all probability the nurse is already immune to the more common contagious diseases."

Shirley Thompson, nursing director at the University of Oregon Medical School Hospital, sums up the nurses' majority opinion thus: "It's past time for us to adopt the viewpoint that the nurse cares for *all* patients, regardless of their diseases!"

With these points and many more to back up their reasoning, just why do two-thirds of the respondents seem to change their minds when answering the second question? Why do they agree that the private duty nurse is *not* obligated to accept *every* risk case she's called on?

The answer in a nutshell is: They recognize human limitations. They know that the best nurse is often the one who realizes when her knowledge and

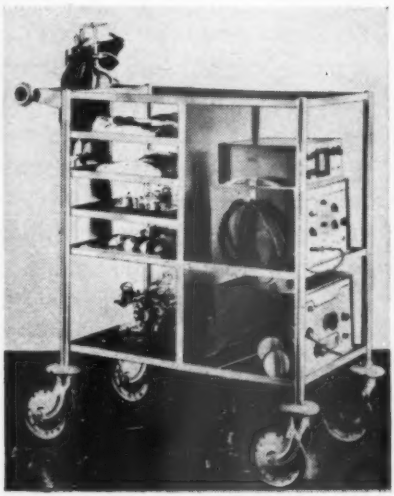
strength aren't adequate to care for a particular patient. They recognize that the private duty nurse may have family commitments that rightfully make her say no at times.

The Committee on Ethical Standards of the American Nurses' Association points out: "Each nurse has other obligations in addition to those related to her profession. So when a conflict arises, it's her responsibility to make . . . a decision in the light of her particular situation."

This doesn't mean the A.N.A. or the profession in general approves of any nurse using such reasons falsely to avoid risks.

Says Blanca Jo Gothard, director of the official registry in Denver, Colo.: "The nurse makes her qualifications known to the registrar, including her limitations. The registrar should make sure she doesn't assign an R.N. to cases the R.N. isn't prepared to handle, or to patients she's not physically able to nurse. But once the registrar has made her choice, she expects the nurse to ac- [*More on 80*]

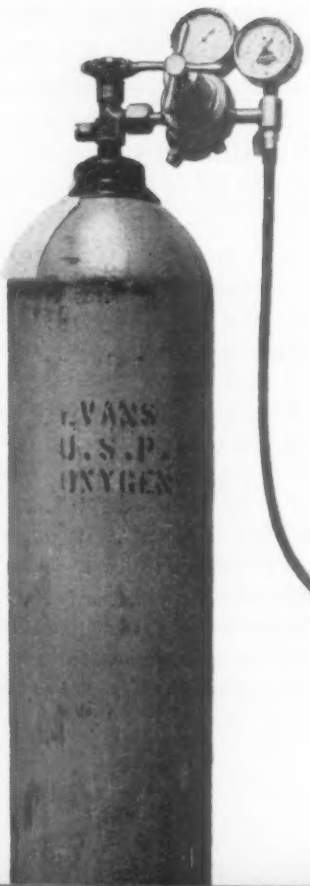
'BRING THE CARDIAC CRASH CART!'



That's an order nurses may soon be hearing and passing on to others as more hospitals start using the new crash cart shown here. Designed with the help of staff members at Grasslands Hospital, Valhalla, N.Y., the cart has space for most equipment normally needed to combat cardiopulmonary emergencies. The items it carries include (left) oxygen, drugs, thoracotomy and endotracheal sets, and a suction pump; (right) a pacemaker and a defibrillator.

AN RN REFRESHER

GIVING OXYGEN THERAPY



It took Cathy Grant (as I'll call her) just twenty minutes to discover how much she'd forgotten about oxygen therapy.

It was her first day of duty after several years away from the bedside. And she entered the ward as excited as a brand new probie. Then she saw the oxygen therapy patients: one with a catheter, two in masks, one in a hood, one in a tent.

Cathy spent the next twenty minutes studying the array of complex-looking equipment that served each patient. Then she gave up and reported to the supervisor that she just couldn't handle the new O_2 equipment.

Fortunately, the hospital had

If your knowledge of how to use old and new O_2 equipment needs brushing up a bit, Cathy Grant's experience will help you

By Frances B. Arje, R.N.

a program of in-service training in oxygen therapy. So Cathy was able to learn what she needed to know in a short time.

"It was lucky for me I didn't try to bluff it through," Cathy told me later. "When I was finally ready to give oxygen, I drew a patient who really put me through my paces!"

Because Cathy's experience covers most phases of oxygen therapy, I present it here much as she told it to me.

Said Cathy: Mr. Carter, an accident victim with chest injuries, was unconscious from shock and loss of blood when they brought him to my ward. Dr. Phipps, the resident, prescribed oxygen by mask under moderate pressure, at 90 per cent concentration.

I knew there was no piped oxygen outlet in the ward; so I had the porter go to the fireproof closet and wheel in a cylinder and other needed equipment. We had no special cylinder base available, so the porter helped me lash the heavy cylinder to the head of the bed to prevent its tipping over and damaging the regulator.

Now I was all set with the basic equipment needed for any form of oxygen therapy: (1) a regulator, (2) a supply of oxygen, and (3) an administering apparatus.

More▶

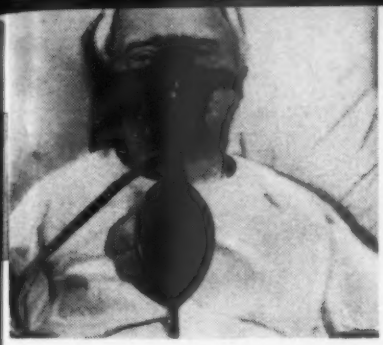
The Three Basic Parts of Oxygen Therapy Equipment

1 **Cylinder regulator**

This reduces the pressure of the oxygen as it leaves the cylinder and controls the rate of flow to the patient. In a pipe-in system, a flowmeter at the wall outlet controls the rate of flow from the pipeline.

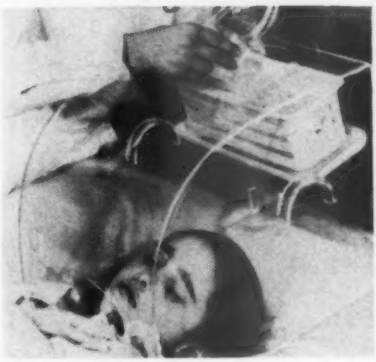
2 **Source of supply**

A standard steel cylinder holds 244 cubic feet of 99.5 per cent pure oxygen at a pressure of 2,200 pounds per square inch and at a temperature of 70 degrees F. Where a pipe-in system is used instead, a cylinder manifold or bulk-storage tanks may be the source of supply.

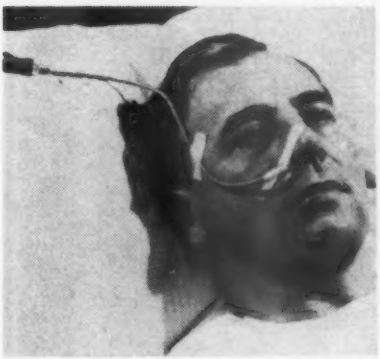


3 Administering apparatus

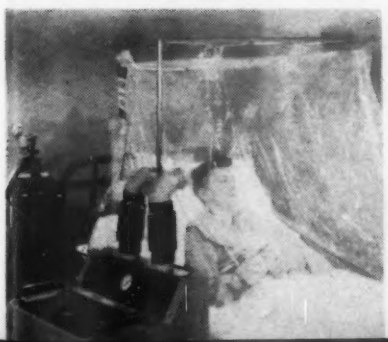
Mask: Numerous styles are available; all have a face piece, a breathing bag, and straps to hold the mask in place.



Hood: An air injector (concentration meter) is attached to the cylinder regulator outlet to provide ventilation inside the hood.



Catheter: A humidifier is attached to the cylinder regulator outlet to moisten the oxygen. The tip of the catheter is lubricated.



Tent: Numerous types are available; all provide means of regulating humidity and temperature and all permit the escape of CO_2.

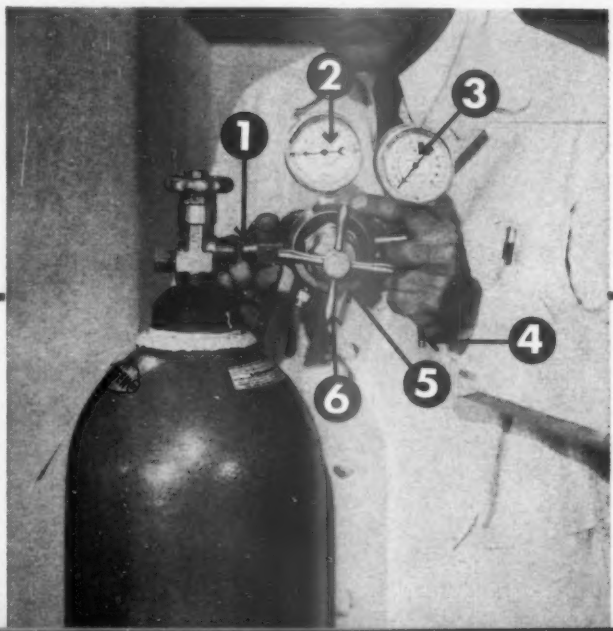
More▶

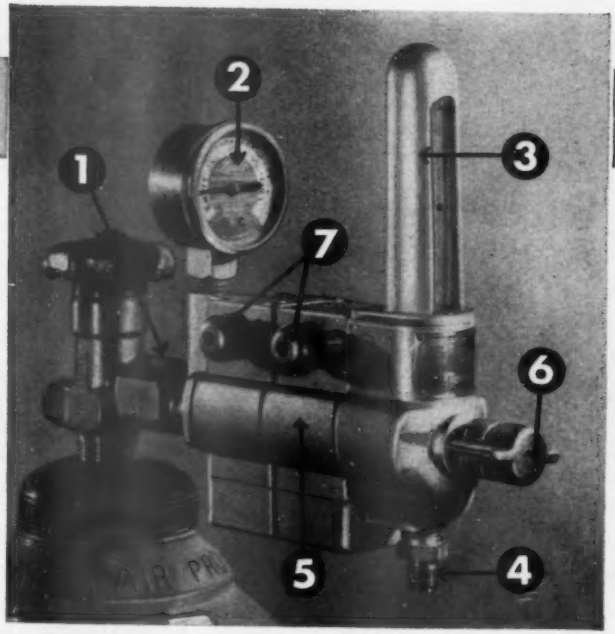
Three Common Types of Cylinder Regulator

These regulators appear different at a casual glance, but all have the following parts in common: (1) a regulator inlet; (2) a cylinder contents gauge; (3) a liter-flow gauge (one type has a round-faced Bourdon gauge; the others have a tube-shaped Thorpe gauge called a flowmeter); (4) a regulator outlet to which oxygen tube, air injector, or humidifier may be attached; (5) a regulator mechanism; and (6) a regulator flow-adjusting handle.

Parts the regulators do not have in common are (7) escape valves on the regulator mechanism and (8) a permanently attached humidifier.

(Cylinders are always "cracked" before regulators are attached by opening valve slightly to blow dust from cylinder outlet, then closing quickly.) *More*▶

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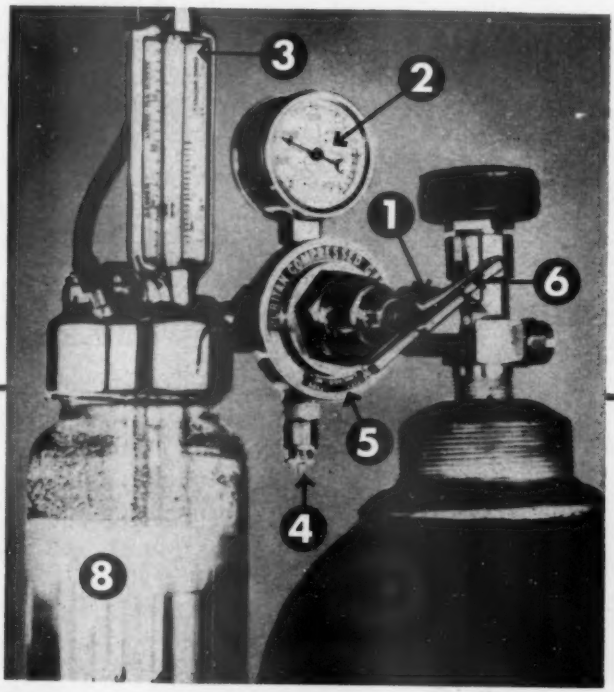
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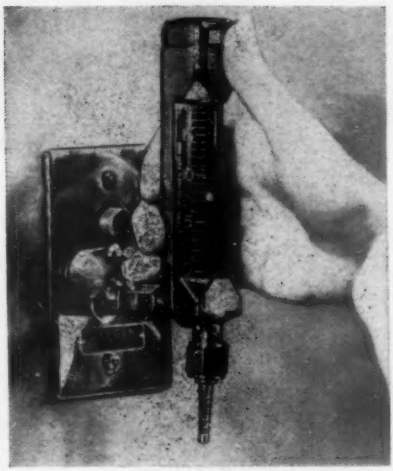


Piped-in oxygen flow is regulated by a flowmeter and valve which are attached to wall outlet.

Nasal catheter set-up must include a humidifier as well as oxygen tubing and a connected catheter.

I opened the cylinder valve slowly until the needle on the contents gauge stopped moving. Next I turned the flow-adjusting valve until the flowmeter registered twelve liters per minute. (See Liter Flow Requirements, page 55.) Then, picking up the mask, I rotated the calibrated disk on the face piece to get low positive pressure.

As I put the mask over Mr. Carter's nose and mouth, I adjusted the head band just tight enough so it would hold the mask firmly in place but wouldn't cut off circulation in Mr. Carter's head, face, or neck.

Now I increased pressure gradually for fifteen minutes until I'd reached the prescribed maximum. At the same time, I reduced the flow of oxygen to nine liters per minute. Mr. Carter was now beginning to regain consciousness. At the end of the prescribed period, I reduced the pressure gradually.

He Got Panicky

Suddenly Mr. Carter opened his eyes and looked wildly in my direction. Then he tried to pull off his mask.

I grabbed his hands. "That's an oxygen mask, Mr. Carter," I

said soothingly. "You must leave it on. You've been in an accident and you're in the hospital. The oxygen will help you breathe easier until you feel better."

Mr. Carter nodded and dropped his hands to the side of the bed. But in a few minutes he was clawing at the mask again.

I got an orderly to hold his hands. Then I put in a call for Dr. Phipps.

I knew that severe anoxia often causes so much nervousness and loss of judgment that the patient won't accept an oxygen mask. But Mr. Carter needed more than a 60 per cent concentration. So we *had* to keep him in a mask or a hood (see table, page 52).

They Switched to a Hood

When Dr. Phipps arrived, he decided that Mr. Carter's reaction to the mask was adding to the strain on his heart and lungs. So he ordered a hood.

The oxygen therapist brought in a new cylinder that had an air injector on the regulator. I marked our first cylinder "In Use" so that anyone who picked it up later would know it was only partly full.

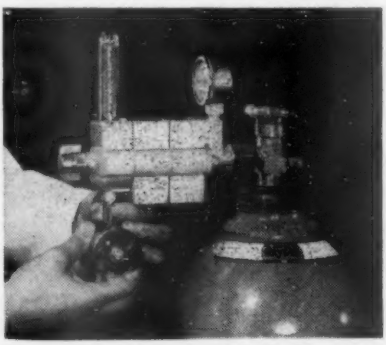
The therapist put ice in the pocket at the top of the hood while I adjusted the air injector. "It gets mighty hot inside these plastic hoods if you don't keep the ice pocket filled," he said.

Regulating the Flow

I rotated the injector meter disk so that the hole at top center gave the prescribed 90 per cent concentration. Then I turned up the oxygen until the flowmeter registered a maximum fifteen.

As I removed the patient's mask, the therapist popped the hood over Mr. Carter's head and secured it. In a few minutes I turned down the oxygen to thirteen.

Next morning when I came on duty, Mr. Carter greeted me



Air injector (concentration meter) is used with some masks and all hoods. It mixes oxygen with room air and washes out carbon dioxide.

INSTRUCTIONS AND PRECAUTIONS FOR

(Precautions are set in boldface type)

FACE MASKS (ALL TYPES)

Read manufacturer's instructions.

Turn on oxygen.

Put mask in place during expiratory phase of patient's respiration.

Fit mask snugly to prevent oxygen leakage, but don't fit so tightly that you stop circulation.

Regulate liter flow.

If breathing bag collapses completely when the patient inhales, increase liter flow. Check for leaks.

An air injector (concentration meter) may be attached to cylinder regulator. Set injector disk to prescribed concentration.

Remove mask every two hours.

Wash and dry patient's face and interior of face piece. Use powder or vanishing cream on patient's face.

FACE MASKS (NASAL)

Use only if patient is conscious, cooperative, and isn't mouth breather.

FACE MASKS (ORONASAL)

Use if patient is unconscious or mouth breather.

FACE MASKS (POSITIVE-PRESSURE)

(The mask may be designed for positive pressure on inhalation, on exhalation, or both.)

Set to prescribed pressure by rotating calibrated disk on face piece.

Start at lowest pressure; take ten to fifteen minutes to reach maximum prescribed. After prescribed time, reduce pressure gradually.

HEAD HOODS

(Many diverse designs for infants, children, and adults. May be called hood, croup tent, aerosol tent, or humidity hood, depending upon attachments. Usually made of clear, hard plastic. May or may not have a base on which patient's head rests.)

FOR USING OXYGEN EQUIPMENT

Read manufacturer's instructions.

Use air injector (concentration meter) to assure adequate ventilation.

Fill ice compartment, if any.

If the hood has no ice compartment, observe patient closely for discomfort due to excessive heat.

If hood has ice compartment, replace ice as necessary.

Attach humidifier, nebulizer, or any other equipment as ordered.

Turn on oxygen.

Place hood over patient's head.

If hood has no plastic sleeve at neck opening, use towel to prevent oxygen leakage.

Use small, flat pillow to support head and neck.

Check oxygen concentration every two to four hours with oxygen analyzer.

CATHETERS

(French, sizes 8 to 18; or plastic disposable catheters, various sizes.)

Select largest-size catheter patient can tolerate.

Measure distance from tip of patient's nose to ear lobe, using catheter. Subtract half inch and mark this distance on catheter with adhesive tape.

Attach humidifier to liter flow outlet.

Use humidifier with any administering apparatus that bypasses mucous membranes of nose and throat. This applies to "shallow" (nasopharyngeal), "deep" (oropharyngeal), and intratracheal administration of oxygen via tracheostomy.

Add tubing, connector, and catheter.

Turn on oxygen.

Lubricate tip of catheter with water-soluble jelly and test for patency of holes in tip of catheter by placing it in glass of water.

Hold catheter in position of greatest "droop," tilt patient's head back, introduce catheter gently into nostril, insert to measured distance.

Keep oxygen flowing while testing and inserting catheter.

Ask patient to open his mouth; look to see that catheter is in correct position just behind uvula. If not, adjust so that it's in the correct position.

Secure catheter in place by taping it to patient's cheek and temple. Use cellophane or adhesive tape.

More▶

CATHETERS (*Cont.*)

Be sure catheter rests on floor of nasal passage.

Fasten oxygen tube to pillow with safety pin and rubber band.

Be sure that pinning to pillow doesn't pinch oxygen tube and that tube isn't kinked.

Remove catheter every twelve hours, and replace with clean, freshly lubricated catheter in alternate nostril. Replace more often if patient has much mucus secretion.

Each time you change catheter, put tape in different spot on patient's face.

TENTS (ALL TYPES)

Read manufacturer's instructions.

Assemble tent outside patient's room.

Avoid long tube that may become kinked and shut off oxygen.

Wheel to bedside with tent canopy folded up over support rods.

Have oxygen flowing at "flood" (fifteen liters per minute) before putting tent over patient.

Tuck edges of tent well under mattress to prevent oxygen loss. Avoid brushing tent against patient's face when you fold it off support rods.

After fifteen minutes, turn oxygen down to ten or twelve liters per minute.

Check concentration in tent every two to four hours with oxygen analyzer.

Before using unfamiliar oxygen analyzer, always read manufacturer's instructions.

Check temperature and humidity frequently.

Watch cylinder content gauge. An empty cylinder may make tent a death trap!

Flood tent with oxygen each time you close tent after giving patient care.

TENTS (OPEN-TOP OR BOX)

Don't allow drafts to blow across top of tent and scoop out oxygen.

TENTS (ICE-COOLED INJECTOR)

Attach air injector meter to outlet of cylinder regulator.

Use grapefruit-size chunks of ice; keep ice supply adequate; empty drip pans frequently.

Be sure water drain is working.

If soda lime is used to wash out patient's exhaled carbon dioxide, renew supply every twenty-four hours.

TENTS (FORCED CIRCULATION)

Make certain cool, dry air doesn't blow directly on patient.

TENTS (ELECTRICALLY REFRIGERATED)

Turn tent switch to "On" and adjust temperature control before you put patient in tent.

Report frayed cords, damaged plugs, or any fault in electrical parts. Have them fixed promptly. Use other administering apparatus until tent is fixed.

SAFETY PRECAUTIONS WHEN USING ANY OXYGEN THERAPY EQUIPMENT

Use only equipment that's in good working condition.

Always mark an opened cylinder "In Use" or "Empty."

Follow manufacturer's instructions for cleaning and storing apparatus.

Put "No Smoking" signs where they're sure to be seen, but don't rely on signs alone: Keep your eye on patients, visitors, and hospital personnel, including physicians.

Disconnect call bells, radios, and phones in patient's vicinity. Ban electric heating pads and razors.

Never use grease or oil on any part of equipment.

Remove from room all cigarettes, matches, alcohol, lighter fluid, and other inflammables.

LITER FLOW REQUIREMENTS

(in liters per minute)

Apparatus	Oxygen Concentrations 40%	50-60%	100%
Face mask	4	6	10
Head hood	6	8	14
Tent	10	12	unlikely
Catheter	5-7	10	impossible

More▶

jovially. He seemed so much improved that Dr. Phipps decided to discontinue oxygen.

I watched the patient closely for a time and soon noticed that he started to yawn every few minutes. His pulse and respiration went up and he told me: "I feel like I couldn't fight my way out of a paper bag!"

Oxygen Needed Again

Recognizing the symptoms of mild anoxia, I called Dr. Phipps. He ordered a 40 per cent concentration of oxygen by deep nasal catheter. I took all the usual precautions for administration by catheter. (See Instructions and Precautions, page 53.)

After two days Mr. Carter was still pretty uncomfortable. His nose hurt, he said, and he felt restless.

Treated for 'Wet Lung'

The next time Dr. Phipps came around, he told me the patient had developed a small patch of "wet lung" and should be kept on oxygen until it cleared up. "We'll put him in a tent," he said, "to give his nose a rest and to allow him to move about a bit."

I followed standard procedure in setting up and operating the tent (see chart, page 54). Before using the oxygen analyzer, I remembered to test the room air to be sure the analyzer worked properly. When the test showed a normal 21 per cent oxygen content in the air, I knew the analyzer was accurate.

I planned Mr. Carter's nursing care so I wouldn't have to open the tent very often. Each time I did open it, I turned the flow up to fifteen for about fifteen minutes afterwards. Then I checked the concentration with an oxygen analyzer before reducing to normal flow.

The Danger of Fire

Because some oxygen escaped into the room every time I opened the tent, I was particularly careful of the fire hazard. From the moment I'd started giving oxygen, I'd constantly kept in mind that I was working with a gas that supports combustion. (See Safety Precautions, page 55.)

I'd even told Mr. Carter he couldn't use his electric razor because of the spark hazard. He'd responded by letting his beard grow!

The day he [*More on 78*]

Exploding Those
MENOPAUSE MYTHS

Jane E. Hodgson, M.D., (above) gives mature, down-to-earth answers to questions that women often ask about the menopause

So many harmful distortions, half-truths, and falsehoods have collected about the subject of the menopause that even the nurse may sometimes find herself confused.

One nurse, for instance, may decide that menopausal symptoms are mostly psychosomatic and that, as a member of the healing profession, she should set an example for others by ignoring the menopause when it comes. Then what happens? Perhaps her climacteric begins sooner than she expected. Or

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maybe it's more severe than she thought it would be. So she becomes unstrung and panicky. She starts fighting her symptoms. And the harder she fights, the more trying the symptoms become.

A second nurse may do just the opposite. She has observed severe symptoms in some of her patients; so she expects the worst. She steels herself to meet this period of life bravely. But it turns out that her climacteric doesn't start till she's in her fifties, and then it's very mild.

This lucky break would be wonderful *if* she had approached the subject in a matter-of-fact way. But she didn't. So now she worries needlessly about difficulties that never appear. She even works up some psychosomatic symptoms that are real and painful and that her doctor finds it hard to relieve.

The common-sense nurse obviously avoids these extremes of attitude. She accepts the menopause as a natural event. She knows its hazards are ones she can avoid or learn to bear. And she encourages her patients to take the same attitude.

Actually, no woman should fear the menopause. For, as any nurse knows, it's a normal physiological change, a simple cessation of menstrual activity.

Many of the accompanying discomforts aren't unique to this period of life. Most women experienced similar discomforts at the onset of the menses in their teen years.

Questions Answered

My women patients ask me many questions about the menopause. Those that follow aren't necessarily the ones they ask most often. Rather, I've selected them because I believe they're of most interest to the nurse:

Q. When may I expect the menopause to start?

A. In your mid-forties, on the average. But don't be surprised if it starts as early as your thirties or as late as your fifties. Some women vary widely from the average.

Q. What are the usual symptoms?

A. A gradual cessation of the menses, of course, with your periods becoming irregular. You may have headaches and hot flashes. You may also go through periods of fright or depression or irritability.

Nearly every woman fifty or

older has a few mild hot flashes. But not more than 15 per cent of all women ever have severe flashes.

Actually, most experience only minor discomfort during the menopause. And some don't experience *any* physical or emotional upset at all. They simply stop menstruating. *More*▶

We Cure Bedsores With Sheepskin

By Luther Davis Jr., M.D.

Are you losing the battle against bedsores? We're winning it with wool!

We've found that the wool of a sheepskin meets all the requirements for preventing ulcers and promoting healing: It's resilient and airy, it distributes pressure evenly, it dissipates moisture, and it doesn't wrinkle or chafe.

We spread the sheepskin on the bed, woolly side up. After three to seven days, we remove it and clean it by scrubbing with soapy water and rinsing with a garden hose. Then we dry it in the sunlight because artificial heat would ruin the leather. Finally, we fluff up the wool with a brush and put the skin back on the bed.

My nurses remind me when it's time to start sheepskin therapy. I prescribe sheepskin for long-term patients who (1) are thin, (2) are subject to continual chafing from dressings and bedcovers, (3) can't turn at will, (4) can't control bowel or bladder function, or (5) have a loss of sensation or of muscular-vascular tone.

One patient had a decubitus ulcer so deep it exposed the sacrum. Twenty days on a sheepskin cured him. An apoplectic patient who was bedridden at home for three years wore out two sheepskins—but he didn't develop a single sore. END

Q. How long does the menopause last?

A. Usually two to three years, though again some women vary widely from the average.

Occasionally a woman continues to have hot flashes even though her menses have stopped. This usually indicates that her ovaries are continuing to secrete small amounts of hormones. The condition is nothing to be alarmed about—in fact, just the opposite. For it's now thought that these ovarian hormones help to stave off hardening of the arteries and coronary disease.

Q. How does the menopause affect a woman's sex life?

A. There's no organic reason why the menopause should either decrease or increase sexual desire and satisfaction. Some women do become frigid at this time, but it's entirely because of emotional upset. On the other hand, a few have such an increase in libido that it makes them restless and uncomfortable.

After the menopause is completed and pregnancy is no longer a hazard, many women have more desire and achieve sexual satisfaction more often.

Q. Is pregnancy possible during the menopause?

A. Yes, as long as you're menstruating. But during this period in life, you do not ovulate every time you menstruate. Hence, the chance of your becoming pregnant decreases, usually from the forties right to the end of the menopause.

Q. What can the doctor do to relieve severe symptoms?

A. In my opinion, the use of tranquilizers is sometimes indicated. They lessen depression and irritability and offset the insomnia sometimes caused by hot flashes. Thyroid extract is indicated for the patient who's suffering from hypothyroidism brought on by hormonal changes.

Do Sex Hormones Help?

Estrogens are also used, but some doctors give them only to the severely distraught patient for temporary relief. They reason this way: The patient's natural supply of estrogen will soon cease. Her body has to adjust to this loss. So why prolong the period of adjustment by boosting her estrogen level temporarily?

Most doctors do not favor the use of the male hormone androgen. Although some gave it in the past to [*More on 86*]

SENATOR HUMPHREY AIDS NURSES SEEKING B.S. DEGREES

The Minneapolis R.N.s who nursed friendly young Nancy Humphrey (above), hospitalized in 1947 as the result of an automobile accident, couldn't foresee the chain of events their able care set off.

During her hospital stay, Nancy became so inspired by the challenge of nursing that she later worked summers as an aide. Then, last year, she enrolled at the Northwestern Hospital School of Nursing.

Four months before she was capped at Northwestern, her father, Senator Hubert H. Humphrey (D., Minn.), shown above congratulating her, introduced Senate Bill 1118 to provide a five-year program of Federal scholarships for nurses. Under this bill, present diploma R.N.s as well as student nurses would be eligible for scholarship grants of $1,000 a year, awarded on the basis of ability and need. These grants would be made for full-time study toward a baccalaureate nursing degree.

Senator Humphrey acknowledges that his daughter's interest

in nursing inspired him to look into the nurse shortage and try to do something to help solve it.

"Do you know," he told *RN* recently, "that Nancy decided to enter nursing on her own? Her decision is one of the most important things that has happened to me. Nursing is a noble profession. I believe the American people are ready to honor their nurses by providing some financial help."

Nurses are as important to the public welfare as other groups now getting Federal aid, he believes. "We're giving assistance (under the National Defense Education Act) to people who are studying languages or taking specified vocational training. Why shouldn't we provide scholarships for nurses?" he asks.

The Senator's bill would appropriate $10,000,000 a year for the five-year program of scholarships. It would also appropriate $30,000,000 a year to help collegiate nursing schools during the same period.

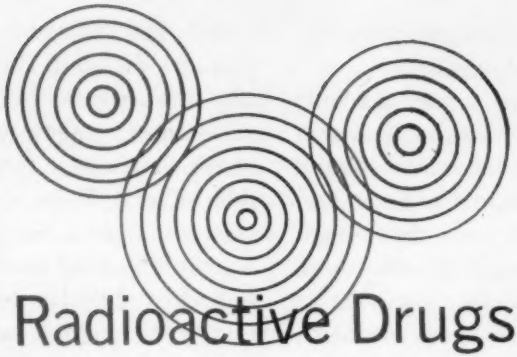
Representative Edith S. Green (D., Ore.) has introduced a companion bill, H.R. 1251, in the House. These measures, known together as the Humphrey-Green bill, have the support of the American Nurses' Association.

"It takes time to get legislation of this kind passed," says Senator Humphrey. "It should be discussed by medical and nursing groups and the public in general, as well as by Senate and House committees. It won't pass this year, but we're going to push hard for it. We'll keep pushing until we succeed." END

He missed his chance

When I found the man still visiting with the new mother after hours, I said in my kindest voice: "I'm afraid you'll have to kiss her good night now and go home."

Like a rocket the visitor shot from the room—and the patient burst out laughing. "That wasn't my husband," she said. "That was my minister!" —MILDRED HILL, R.N.



Radioactive Drugs

They're no more mysterious in their action than other medications, as this easy-to-follow explanation shows

By Morton J. Rodman, PH.D.

The sign on the cancer patient's door reads: "Danger—Radioactive Material."

The duty nurse pauses a moment. She feels a vague fear similar to the fear she experiences when she sees a sign on the trolley bus: "Danger—High Voltage." But she knows—if she's experienced—that atomic radiation, like electricity, isn't dangerous when she abides by the rules for working in its presence. And she's been taught those rules well. So she shrugs off her momentary fear and enters the room.

Fortunately, such warning signs appear less and less often on patients' doors these days as the new atomic isotopes replace radium and the other natural radioactive elements in many types of treatment. Because the isotopes are created for particular purposes and are controlled in strength, the hazards accompanying some radioactive treatments are greatly lessened.

The new isotopes must be handled with respect, of course. But when used diagnostically, many of them aren't any more dangerous to the patient and to

THE AUTHOR *is Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N. J.*

those who care for him than other types of drugs are.

This increase in safety is only one of the advantages some of these isotopes have over natural radioactive elements. To understand why this is so, let's review briefly the nature of the atom. Then we'll consider just what an isotope is and what is meant by "radioactive." Finally, we'll look at some of the new radioactive isotopes and see how they do their work.

Understanding the Atom

These are the basic points to keep in mind:

¶ The atom is the building block of the universe. Just as building blocks are put together to erect structures ranging from a simple wall to a complex skyscraper, so atoms join together to build molecules of all the chemical compounds.

¶ Scientists used to think the atom was an indivisible particle of matter. But now they know that each atom is a bundle of smaller particles, held together by interacting forces. The best-known of these particles are called protons, neutrons, and electrons.

¶ Each atom of an element usually has the same number of particles within it. But occasionally the number of neutrons varies, making some of the atoms of the same element weigh more than others. These atoms of an element that differ in atomic weight are called *isotopes*.

¶ Most elements are stable—that is, they don't break up of their own accord. But a few elements, such as radium, are unstable. As they disintegrate, they continually throw off particles of matter and energy rays. The rays are classified as alpha, beta, and gamma radiation. This action is called radioactivity.

There's the background. Now here's what's been done to use radioactivity in the diagnosis and treatment of disease:

Early in the present century medical scientists discovered that, under proper conditions, these particles and radiation could sometimes change or destroy diseased or malignant tissue without seriously harming healthy cells. They also found that small quantities of radioactive elements could be used as tracers to check up on some biochemical activities of the body. But their use was limited in both these areas because they were

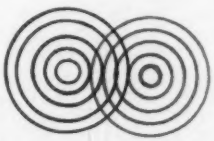
scarce, expensive, and difficult to handle.

With the development of atomic science, it has become possible to create, artificially and at a relatively small cost, a whole new array of radioactive elements. This can be done by placing selected elements in an atomic reactor and bombarding them with neutrons. Many of the atoms are changed enough to become isotopes of their parent element. Or more important today, the waste products of an atomic pile can be used to produce such isotopes.

In either case, the isotopes immediately begin to disintegrate, emitting ionizing radiation for a predictable length of time. This action provides medicine with a marvelous new tool.

Sodium radio-iodide (I-131) is a good example of the new radioactive drugs. Given in minute traces, it helps the doctor tell whether his patient's thyroid gland is functioning normally or not. Given in larger doses, it oft-

RADIOACTIVE ISOTOPES



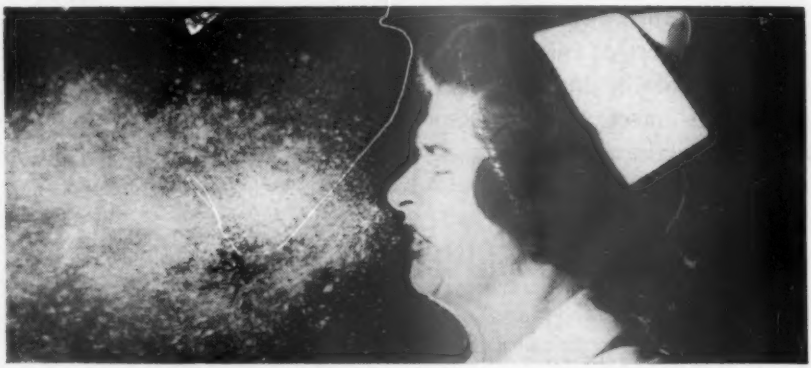
Chromic radio-phosphate (P-32)
Radio-chromic chloride ($Cr\text{-}51Cl_3$)
Radio-cobalamin concentrate (Co-58 and Co-60)
Radio-cobalt chloride (Co-58 and Co-60)
Radio-ferrous citrate (Fe-59)
Radio-gold (Au-198) colloid, N.N.D.
Radioiodinated glyceryl trioleate (I-131)
Radioiodinated iodipamide sodium (I-131)
Radioiodinated methyglucamine diatriozoate (I-131)
Radioiodinated oleic acid (I-131)
Radioiodinated rose bengal solution (I-131)
Radioiodinated (I-131) serum albumin human, N.N.D.
Radio-iridium (Ir-192)
Sodium radio-chromate (Cr-51), N.N.D.
Sodium radio-iodide (I-131), N.N.D.
Sodium radio-phosphate (P-32), N.N.D.
Tritiated water (T_2O)

en controls hyperthyroidism.

If a nurse opened a capsule containing a diagnostic dose of radio-iodide, she wouldn't see a thing inside it! But the iodine atoms are there. Billions of them coat the inner surface of the capsule, each giving off particles and rays as the iodine disintegrates.

Soon after the patient swal-

Sneeze in Slow Motion



This slow-motion photograph shows how a nurse can blanket the air with staphylococci and other organisms when she comes on duty with a cold. Once airborne, these organisms float in natural air currents through the hospital's rooms, corridors, stair wells, and elevator shafts. Often they settle in areas of the building far distant from where they originated.

The close-up picture is from a new color film, "Hospital Sepsis, a Communicable Disease," sponsored by the American Medical Association, the American College of Surgeons, and the American Hospital Association. The film was produced by means of a grant from Johnson & Johnson and was made under actual hospital conditions. It shows how staph infections are spread and what nurses and other hospital personnel can do to prevent such spread.

A loan copy of the film is available from any one of the sponsoring organizations. END

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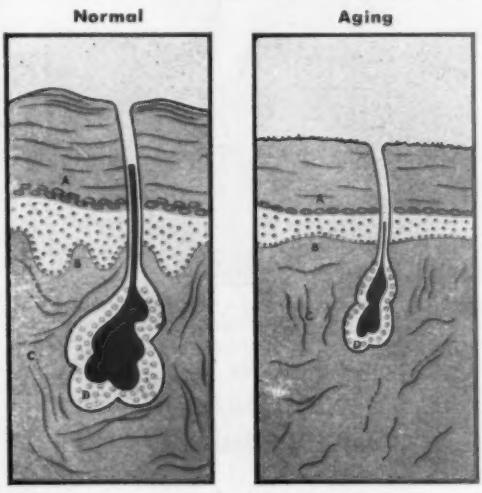
CURRENT CLINICAL STATUS OF TOPIC

At the Clinical Research Division of Helena Rubinstein,® studies devoted to the topic hormone approach to the aging-skin problem have been strongly influenced by th stated opinions of recognized clinicians as well as by results recorded in the curre medical literature. For years this group has been closely identified with dermatolog research in this phase of clinical medicine.

Aging Skin Linked with Waning Sex Hormones—Skin changes "constantl accompany the advance of the climacteric."[1] Aging female skin may appear dr wrinkled, inelastic,[2] and feel "thinner...less resilient."[3]

Aging Skin and the Estrogen Decline—Marked changes of the skin occur "whe the normal production of estrogen decreases."[3]
Changes in the epidermis: "The epidermis becomes thinner and the outermost horn layer appears looser."[4] Epithelial cells are "small in size and poorly differentiated," an "normal projections of the epidermis into the cutis...absent."[5]
Changes in the dermis: "Flattening of the papillae...is one of the most characteristi changes."[6] "The corium decreases in thickness with loss of elastic and collagen fibers." "Collagenous fibers grow thinner...elastic fibers...show clumping, shortening, thicken ing...subcutaneous fat shows degeneration...water content is reduced."[4]

Aging Skin and the Progesterone Decline—"Progesterone...has a strikin growth-promoting effect on sebaceous glands."[8]



Changes in Female Skin
Upon Aging—(shown schematically)
A—Epidermis *B—Papilla*
C—Corium *D—Sebaceous Glands*

Changes in sebaceous apparatus: I aging skin, sebaceous glands "be come much reduced in number," "...smaller and less active."[7]

Replacement Therapy with Topical Hormones—"Estrogenic hor mones...progesterone...penetrate the intact skin rapidly and with grea ease."[9] Applied locally, steroids "have a profound effect upon the skin and its accessory structures."[10]

Controlled Studies with Topical Hormones—*Estrogens:* Published studies[10,11,12] confirm that topical estro gens provide favorable response in aging female skin. Observations included greater succulence of the epidermal cells[11] and derma,[12] and im proved elasticity.[12] Epidermal prolif eration, new formation of elastic fibrils and increased vascularization were reported.[10]

Oral[5] or parenteral[13] estrogen did not produce these effects. It was stated that "there is definite support for the anti-wrinkling effect produced by the use of hormone cosmetics, based upon (a) the thickening of the epidermis, (b) plumping of the collagen fibres."[14]

ORMONE THERAPY IN AGING FEMALE SKIN

rogesterone: Results of topical progesterone applications on aging female skins were ompared with those observed with estrogen creams and enriched placebos.[15] Skin-urface and biopsy examinations demonstrated that progesterone creams increased the urface oil and epidermal emolliency.[16]

strogens Combined with Progesterone: A face cream* containing 10,000 I.U. of atural estrogens and 5 mg. of progesterone was tested on aging female skin.[16] Surface nd histochemical studies revealed that nightly applications produced: a) hydration, or lumping (estrogen effect), and b) increased natural oil and emolliency (progesterone ffect). Controls with estrogen creams indicated that the dermatologic effect of the ombined cream appears to be enhanced by the synergistic action of the *two* hormones. ffects on menstrual cycles and significant changes in vaginal smears or urinary hormone xcretion were not detectable. Patch tests (Schwartz-Peck and Draize-Shelansky),[17] howed freedom from irritation and sensitization.

Hormone concentrations used in foregoing studies have been established to be "entirely afe"[18] and free from systemic effects.

eauty Through Science—The cosmetic industry has reported great strides made n recent years toward the achievement of superior products through scientific formu-ation and control. The Clinical Research Division of Helena Rubinstein® has contributed ignificantly to these advances.

Helena Rubinstein products have set the standards for the cosmetic industry at large. All preparations must pass the most rigid requirements for scientific rationale, attractive-ess, efficacy, safety. Compounded with the same care as your topical prescriptions, you ay recommend them with complete confidence. Helena Rubinstein Research is engaged n a never-ending search for improved cosmetic preparations and methods that will ontinue to offer increasing rewards for your patients.

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lows the capsule, the iodine atoms enter the blood stream. The thyroid is greedy for iodine. So its tissues snatch the atoms from the blood and use them for building the hormone thyroxine.

When the doctor holds a detecting device over the patient's throat, the disintegrating iodine gives off gamma rays that pass through the patient's neck. If the device shows a normal count of rays, the doctor knows the thyroid gland has absorbed only the usual amount of iodine and is probably functioning normally. If the device shows a high count, the gland may be overactive.

Somewhat larger doses of radio-iodide are used to treat hyperthyroidism. Because most of the rays it gives off are of the short-range beta type, these rays destroy thyroid cells without damaging near-by body tissues.

A similar treatment sometimes helps patients with angina pectoris and congestive heart trouble. After the doctor gives radio-iodide, the following sequence of events occurs:

(1) The thyroid becomes less active. (2) With less thyroid secretion to stimulate them, most of the body cells also slow down biochemically. (3) They don't take as much oxygen from the blood. (4) This enables the heart likewise to slow down, giving it a better chance to repair its own tissues and to reduce the chance of heart failure.

Radio-iodide is also useful in locating "hot" cancerous thyroid tissue that has wandered to distant parts of the body. Such tissue absorbs radioactive iodine as the parent gland does, helping the doctor to find these small metastases.

Doctors have tried to treat thyroid cancer itself with radio-

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iodide. But unfortunately, only about 10 per cent of thyroid cancers will pick up this drug.

The high doses needed to knock out cancer cells in treatments such as this tend to damage bone marrow and depress blood-cell formation. Because of this destructive effect, medical men are using the new radioisotopes to fight polycythemia vera, chronic leukemia, and other blood diseases in which the bone marrow produces too many cells.

In polycythemia, for example, red cells crowd into the blood until it becomes so thick it can barely flow. X-rays have occasionally been used to slow down this excessive blood-cell production. But to produce such an effect, the patient's whole body had to be irradiated.

Better Than X-Rays

Sodium radio-phosphate (P-32), another of the new radioisotopes, has two advantages over X-rays for such conditions: (1) it usually slows down blood-cell production for a longer time and (2) it seldom causes radiation sickness.

Radio-phosphate is picked up

by all rapidly growing tissues, so it's useful in locating tumors, particularly those in the eye and brain. In some hospitals, the surgeon may order an intravenous injection for the brain-tumor patient. Then, when he opens the skull, he explores with a delicate probe containing a tiny Geiger counter. By probing time and again, he maps the limits of the tumor and makes sure he gets all of it.

If he needs to verify that there is a tumor in the brain, or if he wants to locate the tumor before opening the skull, he can give the patient radioiodinated serum albumin. This drug sends out long-range gamma rays that go right through the skull and can be picked up by sensitive counters.

It Goes Everywhere

Radioiodinated serum albumin can also be used to get helpful information about the patient's circulatory system. Injected intravenously, it mixes with the patient's blood in ten minutes; and its atoms can easily be traced anywhere in the body.

In most of the diagnostic uses of radioisotopes we've discussed,

the amounts of radioactive elements used can't harm either the patient or the doctors and nurses attending him. But what of cancer treatment, where much larger doses are required?

Here, those attending the patient must observe special precautions to prevent potential radiation damage. But even so, the radioisotopes used have an important advantage over the natural radioactive elements: they decrease rapidly in strength.

Radio-gold (Au-198) provides a good example of this characteristic and what it means. This isotope is often injected into the chest or abdomen of a cancer patient. Its particles cling to the inner walls of these cavities, giving off radiation that stops fluid from forming. This action cuts down edema and relieves the patient's severe discomfort.

Meaning of 'Half-Life'

All radioactive materials have a half-life. This means that the amount of radiation they emit decreases by half within a certain time, by half the remainder within another identical length of time, and so on. The half-life of most man-made radioisotopes is measured in days.

Trained persons working with a patient who has been given a

radioisotope know exactly the original radiation level of the isotope and just how much it will decrease in stated periods. In the case of radio-gold, they know the original radiation will fall to half its original amount in less than three days, to half of that in three more days, etc.

On the day the drug is injected, the nurse may have to wear a film badge or a pocket meter to detect any possible radiation she may receive. She may have to work fast so that she stays with the patient no longer than a specified time. But on each succeeding day, she can spend more time with the patient.

There's no substitute, of course, for a precise knowledge of the rules for working with each isotope and for proper disposal of any radioactive wastes. The nurse needs to learn these rules and to follow them carefully.

When she does, she can do her work with confidence, knowing that she's in no more danger when helping the patient who has been given a radioisotope than she is when caring for her other patients. END

Giving Oxygen Therapy

Continued from 56

finally came out from under his tent, he looked like a Cuban revolutionary. "May I shave now, Boss?" he asked with a grin.

Later he said: "Mrs. Grant, you sure know how to use the gadgets. It made me feel good the minute I saw you knew what you were doing and weren't going to blow me up with all that oxygen!"

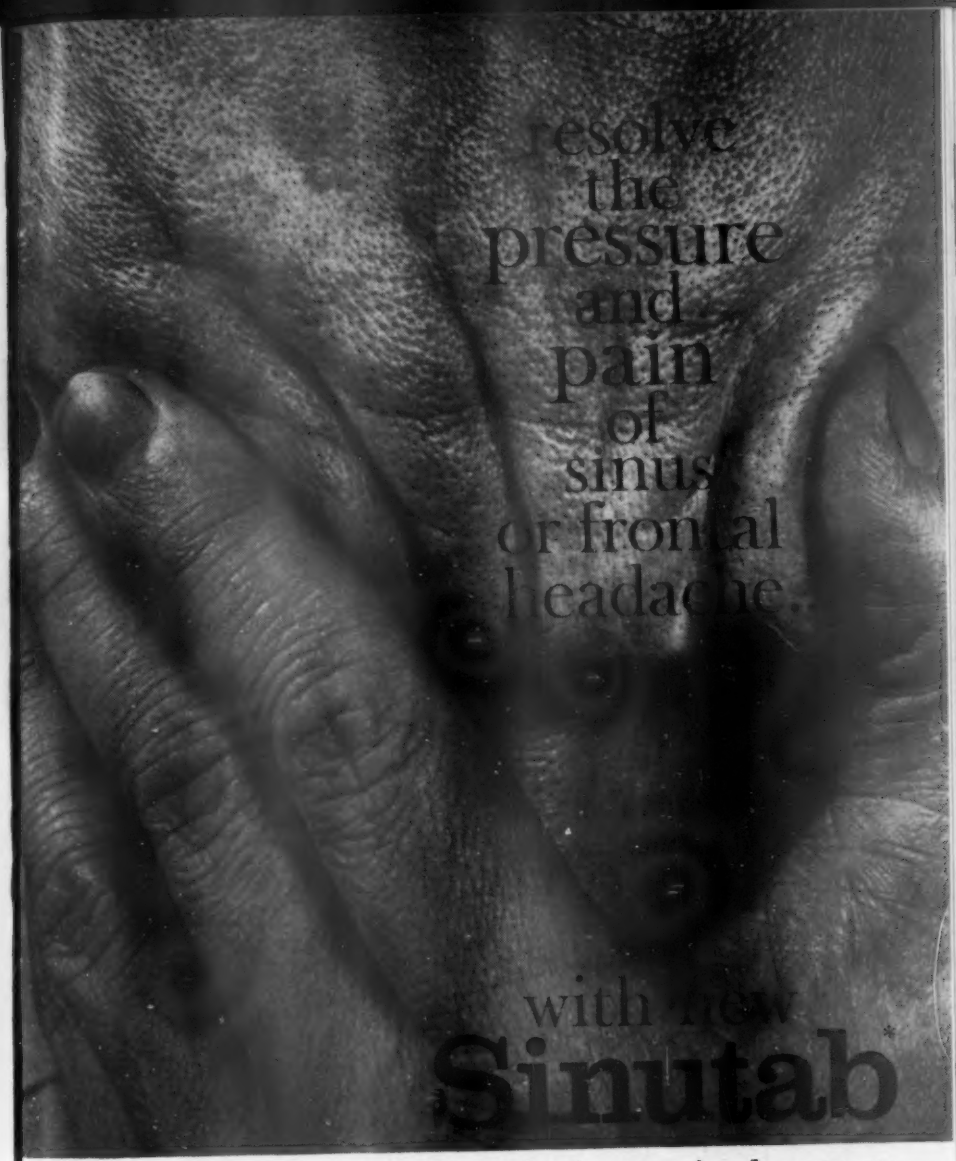
His compliment made *me* feel good too. It also made me remember what I'd learned in oxygen therapy class.

Know Your Equipment

"Unfamiliar equipment may scare you at first," the therapist had said. "But just take your time. Look it over. Think about what it's supposed to do. Figure out how each part does its work. Then read the manufacturer's instructions and they'll make sense."

He had concluded with a statement that Mr. Carter had just confirmed: "Nothing reassures the oxygen therapy patient so much as knowing that the nurse knows her job."

END



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DOSAGE: *Adults,* two tablets every four hours. Prophylactically, one tablet every four hours. *Children 6 to 12 years,* one-half adult dose. SUPPLIED: Bottles of 30 tablets.

*TRADEMARK

WARNER CHILCOTT

MORRIS PLAINS, N.J.

Risk Cases and The Private Duty Nurse

Continued from 43

cept the assignment without distinction as to risk."

Lydia Gihring, nursing director at the Swedish Hospital in Seattle, Wash., agrees. Then she adds: "It isn't the nurse who refuses a call who gives a hospital the jitters! It's the one who accepts when she doesn't have the knowledge or skill to nurse a particular patient. She's a hazard not only to herself and to the hospital, but to the patient!"

Now, what about answers to the question of extra pay for risk cases? Here there's a wider split in opinion, with 42 per cent in favor and 58 per cent against.

Of those favoring such pay, many believe it encourages more private duty nurses to accept risk cases. Dr. Goodrich C. Schauffler of Portland, Ore., says: "I think all nurses are underpaid and underappreciated. They *deserve* 'hazardous-duty' pay. Almost anybody, even an idealist, will do more for more!"

Dr. Willis E. Brown of the University Hospital of Little Rock, Ark., represents a second popular viewpoint: "Professional fees," he says, "*should* be higher when more risk and responsibility are involved."

The Private Duty Section of District II, California State Nurses' Association, supports this idea, as do many individual nurses.

Why They Need More Pay

Ralph W. Schrader of Sun Valley, Calif., and Marian E. Babbitt of Little Rock both point out that extra pay helps replace uniforms torn by mentally ill or alcoholic patients, or spoiled by strong disinfectants used in caring for risk patients with certain infectious diseases.

"It also helps pay for sickness and accident insurance," Mr. Schrader adds, "and for a brief rest after a long and difficult case."

Mabel Branscome of Wichita, Kan., backs up Mr. Schrader's comments about the need for insurance and occasional rests.

"The private duty nurse spends eight hours daily with the risk-case patient," she points out. "Her exposure to infection

is much greater than that of the general duty nurse who's with the patient an hour a day at the most.

"Usually the private duty nurse works right through weekends until the patient no longer needs her. If she gets sick or just too tired to work for a time, her income stops. She *must* make enough money to help her meet these hazards."

Those who oppose higher pay do so mostly on the basis that the risk-case concept is unrealistic. They say that many other types of duty are just as demanding and hazardous.

Dr. Wilson gives the majority opinion thus: "It's hard to define 'risk case' and 'hazardous duty.' Every nurse should accept the difficult with the easy as a part of her work."

One group that has had experience with higher fees for risk cases says such fees cause more trouble than they're worth. Philip E. Day, nursing director at the Mary Fletcher Hospital in Burlington, Vt., points to the confusion in his state, and cites this example:

"Suppose a patient with an ulcer is also seeing a psychiatrist for analysis. The special who nurses a patient under psychiatric diagnosis is entitled to a risk-case fee. Should she get it in this instance? If so, does she *really* deserve extra pay?"

Elinor L. Keyser, a Denver nurse who has worked under both schedules, much prefers

Double puncture

The interne had performed a lumbar puncture on the victim of a cerebral vascular accident. We were still in the patient's room when the interne's pride and satisfaction erupted.

"Do you know that was my first lumbar puncture?" he asked.

Faint but clear were the words of the supposedly comatose patient: "Mine too!" —CONNIE RYAN, R.N.

For each previously unpublished anecdote accepted, RN *will pay $15 to $25. Address: Anecdotes,* RN, *Oradell, N.J.*

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regular fees. "When we were under the extra-fee schedule," she says, "many patients didn't use specials because they couldn't, or wouldn't, pay the higher fee. The doctor was hesitant to call in a special, and sometimes changed his diagnosis to take his patient out of the extra-fee class.

"In borderline cases it was so difficult to know which patients were actually risk patients that shift nurses sometimes disagreed as to their charges for the same patient! And many nurses on regular cases felt abused because they were working harder and yet were getting less pay than those on risk cases."

It's Still a Problem

These opinions of the private duty nurse's colleagues don't, of course, solve the risk-case dilemma for her. But when she gets calls for risk cases in the future, she'll at least know what others expect of her and can use this knowledge to help her reach a decision that's best for all concerned.

One thing seems certain: Unless she lives in a favored area, she'll probably have to give up any expectation of receiving higher fees for risk cases until more of her colleagues support the idea. END

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NEAREST... to mother's milk in its pattern of vitamins and minerals (more vitamin D in accordance with NRC recommendations)

NEAREST... to mother's milk in its fat composition (no butterfat; no sour regurgitation)

NEAREST... to mother's milk in its ratio of saturated to unsaturated fatty acids

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ENFAMIL POWDER—cans of 1 lb. with measure. 1 level measure of Enfamil Powder to 2 ounces of water for 20 cal. per fl. oz.

1. Macy, I. G.; Kelly, H. J., and Sloan, R. E.; with the Consultation of the Committee on Maternal and Child Feeding of the Food and Nutrition Board, National Research Council: The Composition of Milks, National Academy of Sciences, National Research Council, Publication 254, Revised 1953. 2. Research Laboratories, Mead Johnson & Company.

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Exploding Those Menopause Myths

Continued from 60

combat severe hot flashes, they saw that this male hormone may cause hirsutism and voice changes.

Q. Can I personally do anything to help ease menopausal symptoms?

A. You can do more than the doctor can, simply by taking proper care of yourself. Of course, you should go to the doctor for regular check-ups. But in between, proper exercise, food, and rest will do you more good than medications.

When you're on duty as a nurse, you exercise some of the muscles you never use as a housewife. This is all to the good. Nursing also helps you to keep your mind off yourself; for you obviously can't indulge in introspective worrying when you're caring for those who are ill!

Exercise counteracts the flabby tissues and spreading hips that may sneak up on you during the climacteric. Careful dieting helps, too. For with the change in metabolism that the menopause brings, you usually don't need as many calories.

Finally, you can ease nervous strain by getting plenty of rest. Try to cut down on your responsibilities. Avoid situations, both at home and at work, that you know will make you tense. Take a nap whenever you can. And be sure to schedule an occasional short vacation—a vacation from family responsibilities as well as from nursing.

Q. Should I take steps to guard against malignancy during the menopause? *More*▶

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FLEET ENEMA is more effective than a quart of soapsuds or tap water[2] yet "comfortable to the patient[3]"

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Disposal Unit

for routine administration... pre- or postpartum[3-4] and pre- or postsurgical use... prior to proctoscopy.[5]

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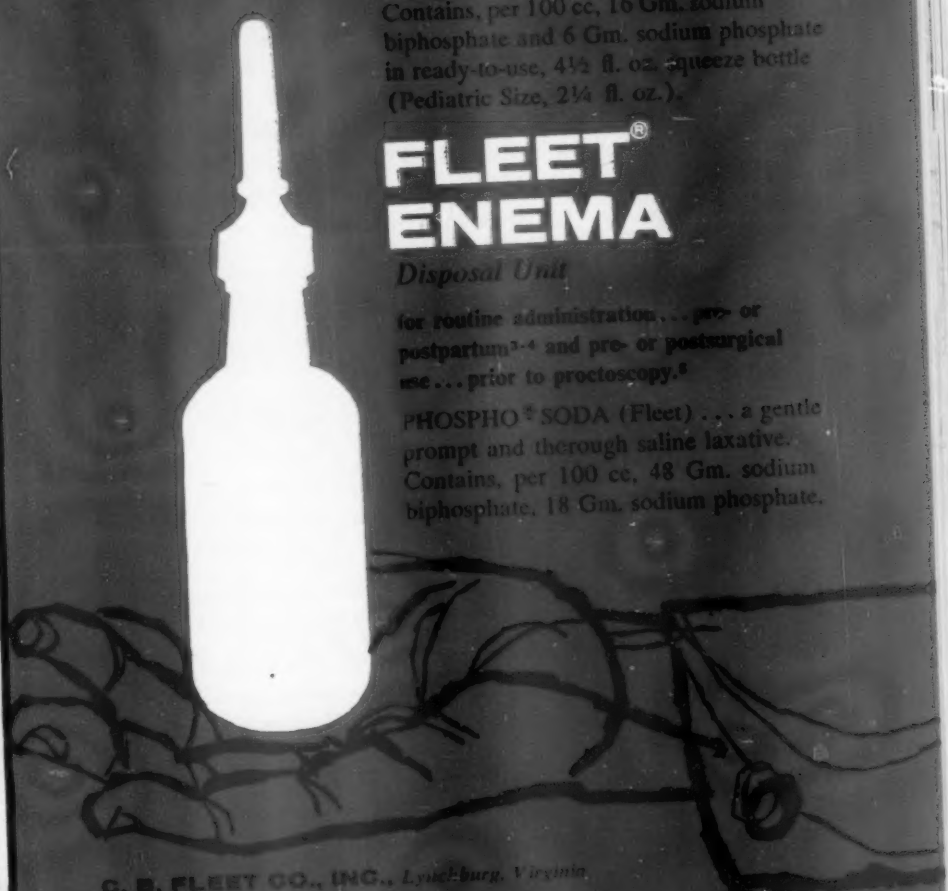

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References: 1. "Injuries to the bowel as the result of an enema." Frech, H. O. and Lanier, L. R., Am. J. Obst. & Gyn., 74:146, 1957. 2. Swinton, N. W., Surg. Gyn. & Obst., 88:813, 1955. 3. Rosenfeld, M. H., et al., Obst. & Gyn., 11:225, 1958. 4. Beckmiller, M. M. and Bowen, G. L., "Textbook of Obstetrics and Obstetric Nursing," 3rd Ed., Saunders, 1958. 5. Rigney, C. (Paper presented to N. Y. St. Ind. Med. Soc., N. Y. C., 1958.)

A. Yes, definitely. This is the one area in which the nurse is often negligent. Like many doctors, she urges others to get regular physical check-ups but "can't seem to find the time" herself.

Check-Up Every 6 Months

The incidence of pelvic malignancy is highest among women during this period. So it's vital that you get a thorough examination every six months. This should not only include examination of the heart, lungs, breasts, and pelvis but should also include blood pressure, urinalysis, and hemoglobin count.

Have Papanicolaou smears taken every two years (more often if the doctor thinks the cervix looks suspicious). In between six-month visits, check your breasts yourself for any lumps. If you find something suspicious, don't hesitate about going to the doctor just because you're a nurse and don't want to appear panicked. It's much better to feel embarrassed because the doctor finds nothing suspicious than it is to let a possible malignancy go unchecked. END

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A Patient's-Eye View of Hospital Nurses

Continued from 39

green comes to wheel Mrs. J. to her ward.

By this time the patient is very hungry and emotionally exhausted. It's not surprising that her doctor finds her in tears when he drops by before lunch. . .

"But," you may protest, "you've exaggerated this case!"

Yes, I have. It's unlikely that one patient would undergo this much "objective" treatment by all the hospital personnel she meets in twenty-four hours or less. On the other hand, every patient faces at least some of these experiences or similar ones. And every patient knows at least some of the loneliness and despair that Mrs. J. suffered.

I agree that such seeming indifference by hospital staff members isn't deliberate. It occurs largely because they view the familiar hospital procedures through their own eyes and not those of the patient. But this fact does not excuse indifferent treatment of the patient.

Of course, the nurse can't be

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Ensey, J. E.: Am. J. Obst. 77:155, 1959

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held responsible for the failure of non-nursing personnel to add to the patient's comfort. But she can set a good example for other members of the hospital team.

What's more, by recognizing that *she* is the nearest thing to a hostess at the hospital, she can largely counteract any adverse impressions others may make.

Just why is she a "hostess"?

For one thing, the patient thinks of her as such—even though the specific term "hostess" may not occur to him. For another, she usually sees more of the patient than any other staff member does. So she has more opportunity to introduce others to him and, in general, to help him feel at home. She's in a key position to provide the emotional comfort that's just as important to the patient as physical comfort.

How to Be a "Hostess"

Now consider some of the specific ways in which a perceptive nurse fulfills her role as hospital hostess:

First, she introduces herself briefly but adequately: "Good morning! I'm Miss Smith. I'll be

here till eleven o'clock, then Miss Jones will be on duty."

While she's getting the patient settled, she assures him there are many fine people on the staff who are glad to help him in their capacities as internes, nurses, technicians, and aides. She explains the hospital routine:

"Dr. So-and-So will be in shortly to examine you. He's the interne." Or, "Miss Brown, our laboratory technician, will probably come in to take blood samples."

If the patient is admitted to a ward or a semiprivate room, the nurse introduces him to those in near-by beds. Later, as circumstances require, she gives simple explanations of the procedures he'll go through. For example:

"You'll be going to the X-ray department soon. Miss Green

"O.K. if I have a friend stay for dinner?"

New Anesthetic Healing Discovery

Specially designed to relieve intense itch — speed natural healing!

A new medicated cream that makes possible more effective relief from skin injuries has been announced by the Noxzema Chemical Company.

Unlike ordinary "first-aid creams," this new formula is not just antiseptic, *but anesthetic, too!* In addition to its bacteriostatic action, it works directly on nerve-endings to bring pain relief.

Identified by the trade-name "Nozain," this greaseless cream combines isobutyl-paraaminobenzoate for almost instant pain relief, with bithionol—the bacteriostatic discovery that guards open cuts from further infection and helps prevent the spread of epidermal irritations. In addition, other ingredients actually speed up the natural healing process.

In cases of intense itch it proves itself of special benefit because it quickly alleviates the pain and thus helps eliminate the patient's dangerous urge to scratch.

Since Nozain relieves without sting or burn, it is specially recommended for children's skin injuries. It is available in tubes at all pharmacies for over-the-counter sale.

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3. America's #1 sunburn remedy. Cools, soothes, brings relief to *sunburn agony* in 3 seconds.
4. Helps heal even difficult cases of infant *diaper-rash burn.*
5. A Noxzema massage brings immediate comfort to patients with *bed-or-bandage sores.*

*surface blemishes

will take you there in a wheel chair. Then when your X-rays are finished, another aide will come to wheel you back.

"We won't be able to give you your breakfast until later this morning because we have to make a test while your stomach is still empty."

Such explanations take only a moment. But they help greatly in making the patient comfortable and relaxed by letting him know what's ahead.

You Owe Him That Much

As a matter of fact, introductions, explanations, and reassurances are simple courtesies that the patient has a right to expect from his nurse. Remember that in his thinking, she's responsible in the same sense that a hostess is responsible for making her guests comfortable. *More*▶

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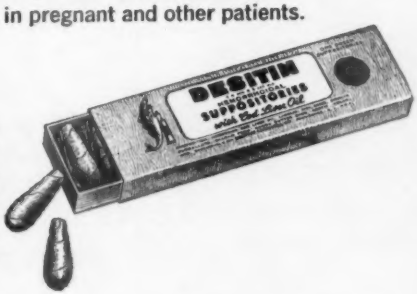

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A good nurse works with speed, efficiency, and dexterity. But she does more than that. As a good hostess, she also exhibits the warm, human touch and the understanding that can do so much to help the patient through an otherwise trying time. END

Prepping for OB Anesthesia

By William Kreul, M.D.

Maternal death caused by vomiting during general anesthesia for delivery is a great tragedy and should be prevented by every means at hand.

The doctor, of course, carries the major burden of prevention. But the OB nurse can also help. Here's how:

¶ When the patient is admitted, ask her when she ate last, what she ate, and exactly when her labor began. The type of food is important in predicting the stomach's emptying time. The stomach probably isn't empty unless three to four hours have passed between eating and the *start* of labor.

¶ If the patient has eaten before labor, call this to the attention of the doctor. Such food intake may make it undesirable to give general anesthesia.

¶ Make sure the patient doesn't get any solid foods after she enters the hospital, even though she may be scheduled for local anesthesia only. If she insists on nourishment, allow only clear fluids in sips.

Whether or not the patient has eaten, vomiting is a serious hazard of general anesthesia. The delivery room nurse should make sure that the delivery table can be adjusted quickly for Trendelenburg position, if necessary, and that a suction machine and an airway tube are close at hand. END

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—LeVan, P., Sternberg, T. H. & Newcomer, V. D.: Cal. Med. 81:210, 1954.

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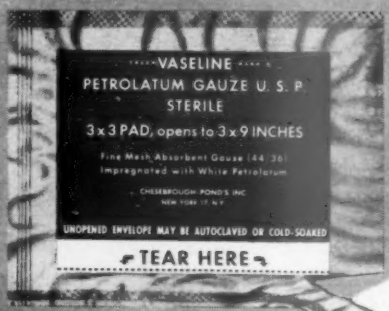

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WHAT'S NEW IN *Drugs*

Antidepressants From Rocket Fuel: New drugs derived from hydrazine, a fuel used in German buzz bombs in World War II, are now being tried out on mentally depressed patients. Included are phenelzine (*Nardil*), nialamide (*Niamid*), isocarboxazid (*Marplan*), and betaphenylisopropyl hydrazine (*Catron*).

Reportedly, these four drugs gently bring patients back to normal without overstimulation, thus cutting down on the need for electroshock treatments. It's thought they work by blocking a brain enzyme, monoamine oxidase, that destroys needed nerve hormones.

A fifth new antidepressant, imipramine (*Tofranil*), is also proving potent, according to some reports. It's unrelated chemically to the rocket-fuel drugs.

An Antibiotic That Fights Fungus: Dermatologists announce that griseofulvin, a new oral antibiotic, has cleared up cases of ringworm and other fungal infections that resisted treatment for many years.

It's available in two products, *Fulvicin* and *Grifulvin*. Taken in capsule form, it enters the blood and thus reaches tissues too tough

for external drugs to penetrate.

Once established among the cells of growing skin, hair, and nails, griseofulvin reportedly prevents the fungi from infecting new cells. As these healthy cells multiply, they push fungus-filled tissues to the surface where they're shed.

Potent Synthetic for Severe Pain: A new synthetic chemical relative of morphine, called oxymorphone (*Numorphan*), is claimed to be safe, potent, fast, and long-lasting in giving relief from pain. And it doesn't cause vomiting and constipation, say some who've used it. It can cause addiction, though, so it must be used with caution.

Relaxant With Many Uses: A chemical called isoxsuprine (*Vasodilan*) is said to relax smooth muscle spasm anywhere in the body.

Doctors reportedly use this new drug to widen narrowed blood vessels in the limbs and the brain. For example, in treating frostbite and various vascular diseases, this action is said to help bring warm blood into cold numbed tissues.

The drug is also said to help clogged vessels carry more oxygen and nutrients to the semi-starved brain cells of patients with cerebral arteriosclerosis. And some say it's highly effective in relaxing uterine spasm. Thus it may prove useful in treating dysmenorrhea and premature labor.

—MORTON J. RODMAN, PH.D.

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ALIFORNIA: Registered Nurses (General uty with opportunity for advancement), new odern 130 bed general hospital in dynamic ollege city in beautiful San Joaquin Valley nly 2 hrs. from Los Angeles. Salary $325 to egin. Differential for evening and nights. 5 ay, 40 hr. wk. Progressive personnel policies. Transportation costs to California will be reimbursed after 1 yr. satisfactory service. Send ll particulars immediately to Director of urses, Greater Bakersfield Memorial Hospital, P.O. Box 26, Bakersfield, Calif.

HARGE NURSES: At L.A. County General ospital receive $432 per mo. for evening and ight shifts. Please write me for full information re job opportunities here. Betty Hartwig, R.N., Box 1311, L.A. County General Hospital, L.A. 33, Calif.

CLINICAL INSTRUCTORS: For Nurse Instructor positions in NLN fully accredited 3 yr. diploma program. Starting salary $545. All the benefits of County Civil Service. Progressive school program, interesting and challenging hospital. Write Betty Hartwig, R.N., Box 1311, L.A. County General Hospital, L.A. 33, Calif. for complete details.

CLINICAL INSTRUCTORS: Psychiatric, Obstetric and Fundamentals. Newly opened School of Professional Nursing. Salary beginning at the rate of $5340 for B.S. Degree or $7080 for Master's Degree. Excellent personnel policy. For complete details write Miners Memorial Hospital Association, Box 61, Williamson, W. Va.

CLINICAL INSTRUCTORS IN MEDICAL NURSING AND OBSTETRICAL NURSING: Large general hospital located in a fine residential district. School of Nursing fully accredited by the N.L.N. with a student body of 193. Educational preparation and experience preferred. Salary dependent upon qualifications. Position open July 1, 1959. Apply Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

DIRECTOR NURSING SERVICE: 142 bed general hospital, JCAH approved. Contact Administrator, Rahway Hospital, Rahway, N. J.

DIRECTOR OF NURSING: $701-851, for large general teaching hospital, 620 beds approximately 90 students. Master's degree required. Apply Personnel Director, 732 East Main St., Stockton, Calif.

DIRECTOR OF NURSING EDUCATION. For long established hospital affiliated School of Nursing in Pacific Coast resort community. N.L.N. provisional accreditation. M.S. degree desirable, applicants with experience preferred. Direct inquiries to Rodney J. Lamb, Administrator, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

DIRECTOR OF NURSING SERVICE: For 238 bed J.C.A.H. approved general hospital, Pacific Coast resort community. Requires B.S. degree, applicants with experience preferred. Direct inquiries to Rodney J. Lamb, Administrator, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

DIRECTORS OF NURSING: (a) Dir. of Nursing, 400 bed modern hosp. leading univ. city, latest facilities, all grad. staff, $8000 up, M.W.; (b) Overseas, Dir. Nursing Service, School, 80 bed hosp. Mediterranean area, Amer. speaking personnel, good salary paid travel; (c) Dir. of Nurses, brand new 80 bed hosp., internationally renowned resort center, southwest, $6000 up; (d) Dir. Nursing Service, Educ. 500 bed new hosp; 200 students, south, $10,000. RN10-3 Burneice Larson, Medical Bureau, 900 N. Michigan Ave., Chicago11, Ill.

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EMERGENCY ROOM NURSE: 3 to 11, 154 bed general hospital located in beautiful residential suburb along the North Shore of Lake Michigan just North of Chicago. Starting salary $340 for days, $370 for evening, $360 for nights, 40 hr. wk. Modern ranch style nurses homes with attractively furnished private bedrooms. Contact Personnel Director, Highland Park Hospital Foundation, Highland Park, Ill.

EVENING HOUSE SUPERVISOR: General Community Hospital, 100 bed JCAH accredited. Town of 18,000, beautiful location on Mississippi River. Graduate staff, 40 hr. wk. Apply Director of Nursing Service, Graham Hospital, Keokuk, Iowa.

FREE TRANSPORTATION FOR REGISTERED NURSES: Spend your Winter in the Sunny Southwest, in New Mexico, "The Land of Enchantment." Vacancies for staff duty on Med.-Surg., O.B., Pediatrics and O.R. Free transportation via 1st Class Air to Albuquerque and return in exchange for 1 yr. employment contract. Apartments available at $43 per mo. Excellent job benefits, no shift rotation. Salaries $300/mo. to start, $15 differential evenings and nights. Write or call Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue S.E., Albuquerque, N. Mex. Phone CHapel 3-5611.

GENERAL DUTY NURSES: For 600 bed teaching hospital in central California. In-service educational program, college community, good fringe benefits, $341-413 salary range. Apply Personnel Director, 732 East Main St., Stockton 2, Calif.

GENERAL DUTY NURSES: 118 bed general hospital located in a beautiful residential section along the North Shore of Chicago. Salary $340 days, $370 eves., $360 nights. 40 hr. wk. Modern ranch style nurses' homes with attractively furnished private bedrooms. Contact Personnel Director, Highland Park Hospital Foundation, Highland Park, Ill.

GENERAL DUTY NURSES: 70 bed, fully accredited hospital, center of Williston Oil Basin, Eastern Montana. Salary starts $289 mo., raises to $319. 40 hr. wk., 7 holidays, accumulative sk. time, full medical and hospital care, insurance and pension plan. Passes on Northern Pacific Railway. Nurses' residence. Write or call Director of Nursing, Northern Pacific Beneficial Association Hospital, Glendive, Mont.

GENERAL DUTY NURSES: Immediate openings in all departments. Starting salary $315, $10 differential for P.M.'s, nights, O.R. and O.B. experience. Salary increases every six months. 40 hr. work wk. Pleasant working conditions and liberal personnel policies in a new modern 250 bed private hospital overlooking the blue Pacific. Please write to Director of Nurses, Hoag Memorial Hospital, Newport Beach, Calif.

GENERAL DUTY NURSES: All departments in 250 bed general hospital. Liberal personnel policies, 40 hr. wk., other fringe benefits. Rooms available in Graduate Nurses' residence if so desired. Apply Director of Nurses, St. Mary's Hospital, W. Palm Beach, Fla.

GENERAL DUTY NURSES: Immediate positions available in 600 bed general hospital in Northeast Ohio. 11:15 PM to 7:15 AM or 3:00 PM to 11:30 PM shift. No pediatric department. Consideration given to the preference of service desired. 40 hr. wk. Generous employee benefits. Write Box AC-2, c/o RN Magazine, Oradell, N.J.

GENERAL DUTY NURSES: Immediate openings in OR, Obstetrical and Medical and Sur-

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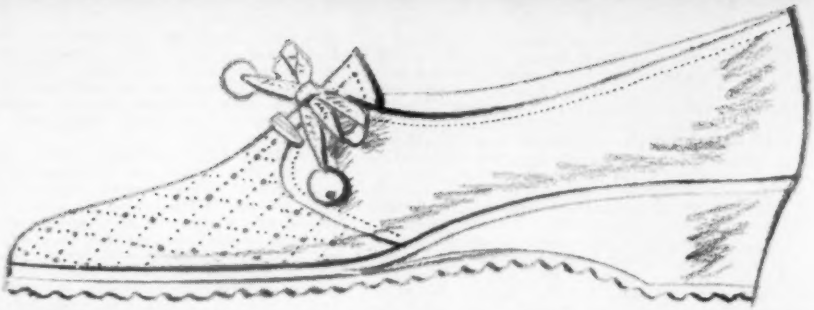

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gical Units. Rotating or permanent afternoon or night tours of duty. Bonus of $20 for OR, afternoon and night tours. New 196 bed hospital, 45 mins from NYC. Modern nurses residence. Apply Director of Nursing, Phelps Memorial Hospital, North Tarrytown, N.Y.

GENERAL DUTY NURSES: For JCAH accredited 210 bed general hospital with NLN provisionally accredited school of nursing. Pleasant suburban environment 35 mi. from NYC. 40 hr. wk. $300 per month. $30 differential for 3-11 and $20 for 11-7. Regular increments, liberal personnel policies including generous sick time and vacation allowance. 8 paid holidays. Scholarship aid available for continued collegiate study. Social Security, good living facilities provided at $30 per month. Call or write Director of Nursing, White Plains Hospital, White Plains, N. Y. Telephone WHite Plains 9-4500.

GENERAL DUTY NURSES: 120 bed hosp, southern Wyoming community of 12,000. Liberal personnel policies. 40 hr wk, starting salary $310 with a charge of $23 for full maintenance, additional $10 per mo for eve and night duty with regular increases. Surgical nurses starting salary $320 plus $5 per call after 5 pm. Write Director of Nurses, Memorial Hospital, Rock Springs, Wyo.

GENERAL DUTY NURSES & OR NURSES: 3-11 p.m. gen. duty, hospital on San Francisco Bay. 5 day wk, salary $335 plus $15 added for 3-11 and $10 for OR duty. Maintenance available. Director of Nursing, Alameda Hospital, Alameda, Calif.

GENERAL DUTY STAFF NURSE: New and modernized 300 bed general hospital offers top salaries and opportunities to advance. Evenings $76.80-$89.60 per wk, nights $73.60-$86.10, days $64.00-$75.60. Openings in Medical, Surgical, Obstetrics, Pediatrics, Operating Rooms and Emergency Room. 40 hr wk, merit increases, liberal policies. On Long Island Sound, 45 mins to N.Y. Modern nurses residence and school. Apply Director of Nursing, Stamford Hospital, Stamford, Conn.

GENERAL DUTY STAFF NURSES: Vacancies on all services due to completion of new wing which has increased bed capacity about 400. Private general hospital with 125 student school of nursing, 3 yr. diploma course. University nearby for advanced study. 40 hr wk. Excellent salary and liberal benefit program, including noncontributory pension plan in outstanding midwestern institution. Centrally located in the city and convenient residential and shopping facilities. Living accommodations adjacent to the hospital available at nominal rent. Contact Personnel Director, Milwaukee Hospital, 2200 W. Kilbourn Ave., Milwaukee 3, Wisc.

GENERAL DUTY, SURGICAL AND PEDIATRIC NURSES: 276 bed gen. hosp, in residential suburb of Chicago. 40 hr wk, cadet salary and live in, $275 day duty, $295 PM duty, $290 night duty plus private room in new nurses residence, 3 meals per day and free laundry of uniforms. Cash salary and live out, $320 day duty, $340 PM duty, $330 night duty plus 1 meal and free laundry of uniforms. Low rental apartments available for married nurses. Planned service increases at regular intervals. Many other benefits. Write Personnel Director, MacNeal Memorial Hospital, Berwyn, Ill.

GENERAL STAFF NURSES: Work in developing teaching center. New 400 bed hospital under construction. Intern-resident program. Outstanding Southern California location

$30 per mo. starting salary, $15 per mo. merit increases at 6, 12, 24 and 36 mos. 40 hr. wk., wks. pd. vacation, pd. sick lv. to 30 days, 7 d. holidays. Apply Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, Calif.

GENERAL STAFF NURSES: Positions available in Medical-Surgical and Intensive Care units in modern 238 bed hospital. Liberal personnel policies. Opportunities for advancement. Beginning salary $335 per mo. with tenure increases, differential pay for 3-11 and 11-7 shifts of $15 per mo. Social security, hospitalization insurance provided by hospital. Apply Director of Nursing, Samuel Merritt Hospital, Oakland 9, Calif.

GENERAL STAFF NURSES: Because we are friendly people it is fun to work in the preferred department of a 200 bed JCAH general hospital enthralled in the extensive building program creating opportunity for advancement. Liberal personnel policies include 40 hr wk, retirement plan, Social Security, pd hospitalization insurance premiums, cumulative 30 day sick leave, 2 wks vacation, 6 holidays, excellent meals at cost, cozy rooms at $20 per mo, in-staff educational program. Approximate initial salary eves $349, nights $343, days $325. Annual increase yearly approximates $215. High standard patient care maintained by nurses permitted to use professional preparations. Ideally located near Detroit with convenient transportation to make off duty hrs. interesting. For details write Director of Nursing. Wyandotte General Hospital. Wyandotte, Mich.

GRADUATE AND ASST. HEAD NURSES: Interested in mental health cases, here's your opportunity. Los Angeles County is establishing a County-wide program in all of its hospitals. It's a new program, resulting from recent Short-Doyle bill passed by the Legislature. Get in on the ground-floor in the hospital of your choice, in Los Angeles, Calif. Write me. Betty Hartwig, R.N., Box 1311, Los Angeles County General Hospital, Los Angeles 33, Calif.

GRADUATE NURSES: General duty for college infirmary, 32 beds, in Hanover, N. H. Starting salary $280. Shift differential of $20 for evenings, $15 for nights. 40 hr. wk., 10 mos. Sept. 1 to July 1 including 3 wks. vacation. Write Dartmouth College Health Service, Hanover, N. H.

GRADUATE NURSES: For general duty 50 bed hospital with new wing. Pd. Blue Cross, laundry and meals in addition to salary of $300. Good personnel policies, sk. lv. and pd. vacations. Located in college town. Apply Superintendent, Northfield City Hospital, Northfield, Minn.

GRADUATE NURSES: Starting salary from $349 to $403 per mo., determined by experience. Vacancies exist at various county institutions for general, mental, tubercular, emergency or dispensary duty. 40 hr. work wk. Certificate of registration in the State of Wisconsin or eligibility thereto. Liberal employee benefits, including sound social security and pension system, pd. holidays, vacation and sick allowance. Vacancies also exist in the following positions: Graduate Nurse II $375 to $433, Graduate Nurse III $418 to $488, Graduate Nurse IV $433 to $509, Nurse-Anesthetist I $418 to $488, Nursing Instructor I $375 to $433, Nursing Instructor II $418 to $488. Apply Milwaukee County Civil Service Commission, Room 206, Courthouse, Milwaukee 3, Wis.

GRADUATE NURSES: Start your profes-

sional career in one of the world's largest hospitals. $375 a mo. is the basic salary and the California climate is included! Write Betty Hartwig, R.N., Box 1311, L.A. County General Hospital, L.A. 33, Calif. for full information. Be ready to work here the day you graduate.

GRADUATE NURSES: For medical and surgical services, modern 263 bed mid-Manhattan hosp. 5 day 40 hr wk. Starting salary floor duty $310, Eves. $350, midnights $340, scrub nurse $320. Uniform laundry, 2 meals per tour. 4 annual increases, 4 wks vacation, 12 holidays, sick lv 12 days per year cumulative. Social Security, Health Service, free hospitalization. Opportunities for special assignments, research nursing bonuses and postgrad. study. Housing agent available. Apply Supt. of Nurses, James Ewing Hospital, 1250 First Ave., New York 21, N.Y.

GRADUATE NURSES: For general duty, 75 bed general hospital, new air-conditioned, with modern equipment. Beginning salary $275 a mo with differential for eve and night duty and operating room nursing. Good personnel policies, 5 day, 40 hr wk, vacation, pd sick lv, holiday time. Located in beautiful central Florida. Apply Director of Nurses, Seminole Memorial Hospital, Sanford, Fla.

GRADUATE NURSES-MALE OR FEMALE: For 500 bed general hospital. Salary $4425 per yr. or higher based on qualifications. Work wk. is normally 40 hrs., 5 days. 30 days vacation and 15 days sk. lv. earned each year, retirement and Blue Cross plans. Located in Shreveport near Barksdale Air Force Base. Write Chief, Nursing Service, Veterans Administration Center, Shreveport, La.

GRADUATE STAFF NURSES: Excellent opportunities for staff nurses in large teaching hospital. New salary scale $370-$400 days a $400-$430 evenings and nights. Room accommodations in attractive residence at reasonable rates. Convenient transportation to h pital. Write to Director of Nursing Servi Dept. R.N., Mount Sinai Hospital Medi Center, 2750 W. 15th Place, Chicago 8, Ill.

GRADUATE STAFF NURSES: Opportuniti for men and women on all services includi Psychiatry and Operating Room. Well planne orientation program, tuition free courses University. Low cost housing in nurses' re dence. Recreational and cultural opportun ties. Salary range $325 to $360. 3 wks vac tion, 6 pd holidays. Follow your impulse a write to: Director Nursing Service, Universi Hospitals of Cleveland, Cleveland 6, Ohio.

GRADUATES: Mercy College of Anesthesi ogy offers an 18 mo AANA approved cour to graduates of accredited schools of nursin Write: Director, Anesthesia Dept., Mou Carmel Mercy Hospital, Detroit 35, Mich.

HEAD NURSE: Medical-Surgical departmen 70 bed, fully accredited hospital, center Williston Oil Basin, Eastern Montana. Sala starts $314 mo., 40 hr. wk., 7 holidays, a cumulative sk. time, full hospital and medic care, insurance and pension plan. Passes Northern Pacific Railway. Nurses' residenc Write or call Director of Nursing, Norther Pacific Beneficial Association Hospital, Gle dive, Mont.

HEAD NURSE, CENTRAL SUPPLY: northern Calif. for large general hospit with nationally accredited school of nursin 3 yrs. of experience part of which should in central supply. Liberal personnel polici and fringe benefits. $394-476 salary rang Apply Personnel Director, 732 East Main S Stockton, Calif.

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HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy and old-fashioned warm care of patients with cancer and allied diseases. Teaching and research center offers valuable experience. Adequate staff of top nurses maintained. University-affiliated in-service education, access all NYC educational programs. Good basic preparation required, learn specialty here where patients receive active surgical-medical-radiation therapy. Not a chronic disease hospital. Teachers college learn-earn plan available for study-experience program on full salary. Staff nurses: day $315-357 mo., eve. $370-412, nite $359-401, 4 wks vacation, 1½ pay for overtime, uniforms laundered, Blue Cross pd by center. Minimum rotation. Suture nurses: base salary plus ½ pay for on call. Housing agent helps you locate. Thelma Laird, R.N., Director of Nursing, Memorial Center, 444 E. 68 St., New York 21, N.Y.

IMMEDIATE OPENING-OBSTETRICAL SUPERVISOR: New, modern 130 bed JCAH approved hospital (22 bed obstetrical department). Deliveries average 110 per mo. Supervisory experience and experience in obstetrics essential, degree or credits toward a degree (may complete college work here in town). Salary commensurate with education and experience. Excellent personnel policies. Travel expense to Calif. reimbursed after 2 yrs. satisfactory service. For full information write, Director of Nursing Service, Greater Bakersfield Memorial Hospital, P.O. Box 26, Bakersfield, Calif.

IMMEDIATE OPENING—SUPERVISORY PERSONNEL: Day nursing supervisor. Qualifications: Degree or credits toward a degree (may complete college work here in town). Supervisory experience preferred. Salary c mensurate with qualifications. New, mod 130 bed JCAH approved hospital. Excell personnel policies. Travel expense to Ca reimbursed after 2 yrs. satisfactory serv For full information write, Director of Nu ing Service, Greater Bakersfield Memor Hospital, P.O. Box 26, Bakersfield, Calif.

IMMEDIATE OPENINGS: For Head Nur in O.B., nursery, medical and surgical dep 3-11 and 11-7, starting salary $315, also sc nurses in O.R., 7-3, starting salary $310. N 200 bed hospital enlarging to 400 beds. C tact Supt. Nurses, Medical Center Hospi P.O. Box 1631, Odessa, Tex.

INDUSTRIAL, OFFICE, CLINIC: (a) Ov seas industrial staff, Egypt, India, So America, Italy, China, $5200 up, must h industrial exp.; (b) Office, Scrub, lead Chicago Doctor, good salary; (c) E.E.N Clinic Nurse, excellent metro. location, $ start. RN10-4 Burneice Larson, Medical B reau, 900 N. Michigan Ave., Chicago 11.

INSERVICE TRAINING COORDINATO To set up and direct inservice training p gram for Nursing Service in 290 bed hospit including geriatric and TB units. B.S. Deg in Nursing preferred; experience in inserv training required. 5 day, 40 hr. week, libe job benefits, room and board available, sta ing salary $400-$450 depending on qualifi tions, interview required at hospital expen Reply giving complete personal data, edu tion, and work experience to Mrs. Marga Nelson, R.N., Director of Nursing, Pres terian Hospital Center, 1012 Gold Ave., S Albuquerque, New Mexico.

INSTRUCTORS: Teach native students cational nursing, outside U.S., $10,000, p air travel, must have Master's Degree;

Med.-Surg., Ped., Maternity leading uni school of nursing. M.W. and East, 9 mon apptmt. $500 month; (c) Psychiatric In-Ser ice, assist in new program, establish nursi affiliation, M.W. to $7700. RN10-5 Burnet Larson, Medical Bureau, 900 N. Michiga Ave., Chicago 11, Ill.

INSTRUCTORS: Obstetrics, Operating Roo and Pediatrics in large city hospital. $3 per mo. Write Director of Nursing, Genera Hospital 1, Kansas City 8, Mo.

INSTRUCTORS-MEDICAL AND SURGICAL Formal and Clinical teaching. NLN full ac creditation, 1 class yearly of approximatel 40 students. B.S. Degree and teaching experi ence required. Liberal Personnel Policies, sal ary based upon background. No Nursing Serv ice responsibilities. 500 bed general hospital Direct transportation to N.Y.C. in 35 mins Write to Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

MALE OR FEMALE HELP WANTED: Sub urban Phila. Hospital. Excellent living and working conditions. 7 on staff, 2 Anesthesi ologists. Apply Director of Anesthesiology De partment, Abington Memorial Hospital, Ab ington, Pa.

MEDICAL/SURGICAL INSTRUCTOR: Im mediate opening. Bachelor Degree and ex perience in teaching required. Liberal per sonnel policies. Admit 1 class a yr., 3 yr. diploma program, 184 bed hospital, 60 stu dents. Apply Director of Nurses, William McKinley Memorial Hospital, Trenton, N.J.

MID-MANHATTAN HOSPITAL: Needs nurses, all tours of duty, 3 charge nurses for afternoon duty, 1 supervisor for medical-sur gical floors. Salaries commensurate with abil ity and preparation. 8 pd. holidays, social se curity, 4 wks. vacation, sk. lv., regular incre ments. Write Director of Nurses, New York Polyclinic Medical School and Hospital, 345 West 50 St., New York 19, N. Y. or call CO lumbus 5-8000.

NEW GRADUATES: As soon as you are li censed you begin at $375 per month in the Los Angeles County General Hospital. Write me for details. Betty Hartwig, R.N., Box 1311, L.A. County General Hospital, L.A. 33, Calif.

NEW MEXICO: Needs Public Health Nurses. Excellent salaries, fringe benefits. Write Mer it System, Box 939, Santa Fe, N. Mex.

NORFOLK GENERAL HOSPITAL: Offers to graduates of accredited school of nursing a 15 month comprehensive course in Anesthesia approved by A.A.N.A. Approved for training under G.I. Bill. Free maintenance plus liberal stipend granted after 3 months. Apply Direc tor, School of Anesthesia, Norfolk, Va.

NURSE ANESTHETIST: 364 bed general hos pital being enlarged to 500 beds. Want to en large present staff of one M.D. plus 7 an esthetists. Salary up to $450 mo. 1 mo. vaca tion per yr. plus retirement and sickness benefits. New air conditioned operating rooms. Apply Chief, Department of Anesthesia, York Hospital, York, Pa.

NURSE ANESTHETIST: 245 bed general hospital AANA member desired. IVE nurse anesthetist on staff. Write Assistant Admini strator detailing experience and qualifications. Memorial Hospital, Casper, Wyo.

NURSE SUPT., CALIFORNIA: For small general hospital, 31 beds, in a growing city of 15,000, central California. Big Navy Air Base under construction nearby. Hospital expansion plans being developed. 40 hr. wk., sk. lv., vacn., 7 holidays, B.C. ins., Soc. Sec. Generally have busy surgery schedule. Please write your qualifications and require-

ments. Hanford Community Hospital, Hanford, Calif. D. O. Bean, Admin.

NURSES: Supervisors and Team Leaders. Accredited 200 bed general hospital in suburbs of Washington, D.C. 40 hr. wk., merit increases. Accept graduates prior to registration. Nearby universities for continued education. Director of Nursing, Suburban Hospital, Bethesda 14, Md.

NURSES: For new 75 bed general non-profit hospital. Resort area. Contact Administrator, South Coast Community Hospital, South Laguna, Calif. HYatt 4-8501.

NURSES: Registered, for accredited psychiatric hospital in Greens Farms, Conn., 1 hr from NYC. Hall Brooke nurses work 8 hr consecutive duty, 40 hrs per wk, nicely furnished Registered Nurses' residence, excellent salary, yearly increment, differential for afternoons, evenings, holidays and week-ends. 7 legal holidays annually, sick lv, vacation, 2-4 wks yearly dependent on length of service, profit sharing plan, psychiatric in-training education, registered or eligible in State of Connecticut. Write to Director of Nursing Service, Hall-Brooke Hospital, Box 31, Greens Farms, Conn. Tel. Westport-CApital 7-1251.

NURSES: California registered or eligible, 40 hr. wk., 3 wks vacation, 9 holidays, $359 mo. start, $10 differential for evening and night duty. Live in the beautiful foothills of the Sierra Nevadas between Sacramento & Lake Tahoe, 2 hrs. to San Francisco or Reno. Living accommodations available at nominal charge, meals $1.50 per day. Write Director of Nursing Services, Weimar Chest Center, Weimar, California.

NURSES: Are you moving to South Bend or coming here to college? Full or part-time positions are available in our new 100 bed hospital. Write to Director of Nurses, South Bend Osteopathic Hospital, 2515 E. Jefferson Blvd., South Bend 15, Ind.

NURSES: A new 50 bed wing, now under construction, allows us to offer attractive positions, all shifts and types. Starting salaries $305 day, $330 eve., $320 night, $320 surgery. No rotation. 215 bed JCAH Hospital, (when construction is completed) Capitol City, growing medical center. Home of Frontier Days, Metropolitan Denver and resort areas 2 hrs. away. Excellent personnel policies, 40 hr. wk., 2-3 wk. vacation, sk. lv., new Nurses Residence at reasonable rates. Apply Dir. of Nursing, Memorial Hospital, Cheyenne, Wyo.

NURSES: Live in the Land of Enchantment where opportunities are awaiting you. Have opening for obstetrical and general duty RNs in accredited hosp. which is situated in a growing and thriving community with ideal climate. Salary range $300-400 mo. for 44 hr duty. Liberal personnel policies. Sick lv plan with 6 holidays per yr. Also we pay differential of $10 extra PMs. If interested please contact Administrator, Clovis Memorial Hospital, Clovis, N. Mex.

NURSES: General duty, 236 bed hospital, 30 mi from NYC. Apartment-style residence. Good salaries, free benefits and pension plan. Modern hospital. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N. J.

NURSES-GENERAL DUTY: Excellent salary, fringe benefits, small hospital residential area. 35 mi from NYC. Apply Mrs. C. R. Gardner, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSES-GRADUATE: Work in new, modern 300 bed hospital, only 35 mins. from New

York City. Exceptional working conditions in congenial atmosphere. Liberal personnel policies and chance for advancement. 4 wks. vacation. Write Director of Nursing Service, Clara Maass Memorial Hospital, Belleville, N.J.

NURSING SERVICE INSTRUCTORS: Do you want to be a part of a terrific staff development program? We have it at the Los Angeles County General Hospital. Beginning salary $545 per mo. Write Betty Hartwig, R.N., Box 1311, L.A. County General Hospital, L.A. 33, Calif. for full details.

NURSING SUPERVISOR: For 3-11 evening shift, liberal personnel policies, new facilities, salary commensurate with qualifications. Apply Associate Director of Nursing, Toledo Hospital, Toledo 2, Ohio

OBSTETRICAL SUPERVISOR: JCAH accredited 210 bed general hospital with NLN provisionally approved school of nursing. 30 bed department averaging 100 deliveries per mo. Supervisory experience and experience in obstetrics essential, degree preferred. Good personnel policies, pleasant living facilities available. Clinical instructor responsible for student teaching. Apply Director of Nursing, White Plains Hospital, White Plains, N.Y. Telephone WHite Plains 9-4500.

OBSTETRICAL SUPERVISOR AND INSTRUCTOR: Responsible for supervision of 76 bed unit, over 3600 births/year and teaching program for nursing students. Degree and/or satisfactory experience. Salary commensurate with qualifications. Liberal Personnel Policies. Direct transportation to N.Y.C. in 35 mins. Write to Director of Nursing, Newark Beth Israel Hospital, Newark 12, N. J.

OPERATING ROOM NURSES: Over 35 yrs. preferred. 32 bed hosp. Small town. Close to San Antonio, Austin and Houston, Texas. Holmes Memorial Hospital, Inc., Gonzales, Tex.

OPERATING ROOM NURSES: For expanding 407 bed gen hosp located on the Long Island Sound just 45 mins. from the heart of NYC. Starting salary $315 plus 2 meals per tour, semi-annual increases for 3 yrs. $15 bonus pd for each stand by and call night. Pd vacation according to tenure up to 28 days, 8 pd holidays, paid sick time, Social Security. Scholarship aid available for continued collegiate study. Apply Operating Room Supervisor, New Rochelle Hospital, New Rochelle, N. Y.

OPERATING ROOM NURSES: For 250 bed hospital. Salary based on experience in operating room nursing. Call time additional. Rooms available in Graduate Nurses' residence if so desired. Apply Director of Nurses, St. Mary's Hospital, West Palm Beach, Fla.

OPERATING ROOM NURSES: For 230 bed general hospital in new, modern, air conditioned six-room operating room suite. Beautiful location. 40 hr., 5 day wk. Salary based on education and experience. Call time additional. Liberal personnel benefits. Apply Director of Personnel, Good Samaritan Hospital, West Palm Beach, Fla.

OPERATING ROOM NURSES: Days and P.M. 154 bed general hospital located in beautiful residential suburb along the North Shore of Lake Michigan just North of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40 hr. wk., attractive salary, other employee benefits. Contact Personnel Director, Highland Park Hospital Foundation, Highland Park, Ill.

OPERATING ROOM SUPERVISOR: Mode
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ing Services, Georgia Warm Springs Founda
tion, Warm Springs, Ga.

OR & STAFF NURSING: Active 100 be
children's medical center. University affilia
tion. Good personnel policies. Apply Directo
of Nursing, St. Christopher's Hospital fo
Children, 2600 N. Lawrence St., Philadelphi
33, Pa. Telephone GA 6-5600.

PEDIATRIC CLINICAL INSTRUCTOR: 10
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in Nursing required. At least 1 or more yr
experience in nursing and preferably some
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vanced study. Write or Call Director of Nurs
ing, St. Christopher's Hospital for Childre
(non-sectarian), 2600 N. Lawrence St., Phila
delphia 33, Pa. Tel. GA 6-5600.

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and night duty, excellent personnel policies
Apply Director of Nursing Service, St. Joseph
Hospital, 2100 N. Burling St., Chicago 14
Ill. Phone Mohawk 4-1700.

PROFESSIONAL NURSES: Positions avail
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Associate Grade $5205, Full Grade $5985 with
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30 days annual leave, 15 days sk. lv., 8 holi
days and retirement plan. Full U.S. Citizen
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experience in psychiatry. Write giving full
particulars: Dr. Joseph Petrus, Director, Con
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N.Y.

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REGISTERED NURSES: Have you heard about the salary increase for nurses in the Los Angeles County Hospital System? Staff nurses, without exp., begin at $375 per mo. ($4500 per yr.) Asst. Head Nurses, with 6 mos. acceptable exp. in an accredited hospital, begin at $417 per mo. ($5004 per yr.) Nurses interested in promotion will find many opportunities to advance at the Los Angeles County General Hospital where Head Nurse and Supervising Nurse positions are frequently filled from our own staff. The active Nursing Service Education Program helps keep nurses well-informed of advances in the fields of medicine and nursing. Why don't you write today for further information about positions available—personnel policies or life in Calif.? Betty Hartwig, R.N., L.A. County General Hospital, 1200 N. State St., Los Angeles 33, Calif.

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Additional Listings

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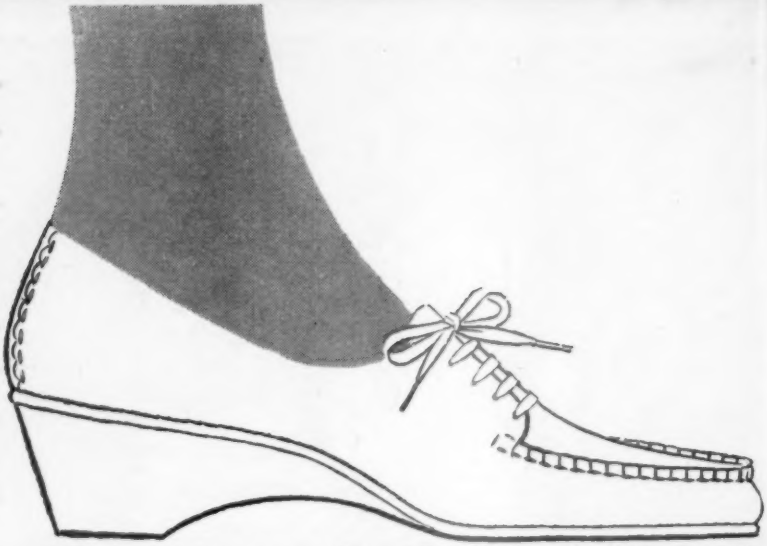

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1. Menger, H. C.: J.A.M.A. 159:546 (Oct. 8) 1955.
2. Published and unpublished case reports.